

1988

Characteristics of family therapists

Keren Marie Humphrey

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Characteristics of family therapists

Humphrey, Keren Marie, Ed.D.
The College of William and Mary, 1988

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CHARACTERISTICS
OF FAMILY THERAPISTS

A Dissertation
Presented to
The Faculty of the School of Education
The College of William and Mary in Virginia

In Partial Fulfillment
Of the Requirements for the Degree
Doctor of Education

by
Keren M. Humphrey
July, 1988

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OF FAMILY THERAPISTS

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DEDICATION

This dissertation is dedicated to my husband, Jim Shelton, whose steadfast support, uncomplaining sacrifice, and quiet strength have sustained me throughout this endeavor.

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Abstract

Keren M. Humphrey, Ed.D.

The College of William and Mary in Virginia, July 1988

Chairman: Fred L. Adair, Ph.D.

The purpose of this study was to explore and describe certain psychosocial characteristics of family therapists according to three different theoretical orientations within the family systems field. The characteristics examined were psychological type preference, personality factors, and the occurrence of loss/transition events in the family of origin.

A review of the literature revealed that, while some research on psychological type preferences and personality characteristics of therapists from various theoretical orientations has been undertaken, there is a serious lack of research on therapists representing the various models of family therapy. Additionally, there has been very little research done on family of origin experiences of therapists in general, and of family therapists specifically.

The sample for this study consisted of 77 family therapists across the United States and Canada representing three different theoretical orientations within the family therapy field: Satir's Process model, Minuchin's Structural

model, and Bowen's Systems model. Ss were chosen by major advocates of the particular models based on their training in and reflection of the principles of that model. All Ss completed an instrument packet containing a Myers-Briggs Type Indicator, an Adjective Check List, and two instruments prepared by the researcher; a Nodal Events Survey, and a Client Information Form. Analysis of variance (ANOVA) was conducted on the results for four scales of the Myers-Briggs Type Indicator (using continuous scores) and ten scales of the Adjective Check List. Data gathered from the Client Information Form and the Nodal Events Survey were reported according to descriptive statistics.

Data from the Myers-Briggs Type Indicator indicated that 59.2% of the total Ss were Introverted types and 89.9% were Intuitive types. Results from the Myers-Briggs Type Indicator revealed that Systems model Ss were significantly different ($p < .05$) from Ss from the Process and Structural models in their strong orientation toward Thinking on the Thinking-Feeling scale. Process and Structural model Ss were not significantly different in their orientations on the Thinking-Feeling scale. Additionally, Systems model Ss were significantly different ($p < .05$) from the Ss from the Process model in their orientation toward Judging on the Judging-Perceiving scale. Systems and Structural models Ss were not significantly different in their orientations on

the Judging-Perceiving scale, nor were Structural and Process model Ss significantly different in their orientations on the Judging-Perceiving scale. Statistical significance was not reached on ten scales from the Adjective Check List.

There were few remarkable events or differences in the loss/transition events in family of origin experiences of Ss. Most serious illnesses of family members were experienced by Ss as adults, with the exception of Systems model Ss, who more frequently experienced their mother's deaths during their adolescence. There was a high incidence (46.7%) of family of origin physical/emotional abuse reported by Ss from the Structural model.

Demographic data indicated that most Ss had worked at a community mental health center, hospital/health center, or private practice prior to their current employment setting, which was most frequently private practice. Investigation of client caseload revealed that Systems model Ss most frequently treated clients as individuals; Structural model Ss most frequently treated clients as whole families; and Process model Ss, while most frequently treating clients as individuals, also frequently treated couples, whole families, and groups. Ss across the three models were primarily from families of 3-5 siblings. Process model Ss were most frequently youngest siblings, while Structural

model and Systems mode Ss were most frequently oldest siblings.

Results from this study indicate some differences of psychological type preference among therapists from three theoretical orientations within the family therapy field. No statistically significant differences were reported on personality characteristics.

Chapter 1: Introduction

Justification for the Study

The theoretical orientation of a psychotherapist is the product of diverse psychosocial factors including training opportunity (Chwast, 1978), societal demands for services (Herron, 1978), personality characteristics (Walton, 1978; Ellis, 1978), and family background (Racusin, Abramowitz, & Winter, 1981). In choosing a particular theoretical orientation, psychotherapists develop a framework not only for understanding and managing client issues, but also as a means for conceptualizing their own personal experiences. More importantly, the theoretical orientation becomes the bridge between these two realms, allowing the therapist to utilize learnings from either realm to inform the other. Thus, what therapists have learned in their own lives about grief or familial conflict has a bearing on their therapeutic practice via their theoretical orientation and, conversely, what is learned about these subjects in one's therapeutic practice has an impact on the personal life of the therapist via that same theoretical orientation.

One such theoretical orientation, family systems therapy, presents an overall theoretical view based on systems theory; however, within the family field there exist diverse theoretical interpretations of systems concepts, the goals of therapy, treatment modalities, the therapeutic relationship, the person of the therapist, and training approaches. Especially important to the question of theoretical orientation as a bridge between the therapist's personal and clinical experiences are factors regarding the therapeutic relationship and the person of the therapist. Gurman and Kniskern (1981), in their extensive review of the outcome literature regarding family therapy, found that, while various theoretical orientations emphasize the person and role of the therapist as an important facet of treatment, much of the research has been conducted without regard for this variable. So important is this factor and so critical the lack of research on this topic, that Gurman and Kniskern specifically point out that:

Future efforts would be wisely directed toward identifying the best matches between family therapist personality factors and particular methods and strategies of intervention. (p. 759)

. . . we would like to see attention directed toward two issues . . . First, what therapist relationship skills are potent for better . . .

and for worse . . . across different methods of family therapy? Second, what therapist relationship skills are uniquely salient within different treatment methods? We believe it is extremely important these questions be addressed, lest much of family therapy evolve into a technology without a soul, which we fear may be on the not too distant horizon. (p. 760)

The impetus for this study, then, arises from Gurman and Kniskern's research suggesting further inquiry into the area of the person and role of the therapist in relation to treatment modality (theoretical orientation) in the family systems therapy field.

Statement of the Problem

Investigation of the person and the role of the therapist in the family therapy field has taken various forms. Alexander, Barton, Schiavo, and Parsons (1976) evaluated therapist relationship and structuring skills in systems-behavioral treatment of families of delinquents. Waxenburg (1973) examined genuineness, empathy, and regard in a short-term family therapy context. Various studies have investigated therapist values and ideology including Shapiro (1974) and Seeman, Weitz, and Abramowitz (1976).

Additionally, there have been studies of various therapist factors associated with outcome. Freeman, Leavens, and McCulloch (1969) linked therapist experience with success in therapy; Postner (1971) examined therapist skill in relation to outcome. More common are studies concerning demographic variables. These include studies of gender effect (Santa-Barbara, Woodward, Levin, Goodman, & Epstein, 1975; Beck & Jones, 1973) and of race (Hill, 1977).

According to Parloff, Waskow, and Wolfe (1978), the therapist characteristics most often investigated, independent of the treatment setting of the clients treated, are personality, mental health, sex, and level of experience. Actually, some research has been done on similar factors among clients, especially with attention to matching of therapist-client characteristics (Wogan, 1970; Bare, 1967; Lesser, 1961). Whatever orientation a therapist assumes, it does not exist in a vacuum; the various facets of one's personality are critical in shaping and refining a therapist's way of conceptualizing and acting within his/her therapeutic practice. Thus, inquiry into the personality of the therapist is appropriate for the present study's aim of examining the relationship between the person and role of the therapist in relation to his/her theoretical orientation.

Another area of inquiry regarding the relationship between a therapist's theoretical orientation and certain psychosocial characteristics is that of family of origin experience. Winter and Aponte (1986) make the case for the influence of family of origin experience on therapists:

For a clinician to effectively use himself within the therapeutic context, he must attempt to understand his own family, past and present, and resolve issues that trouble him and hamper his functioning . . . lack of resolution of a practitioner's family issues hampers his ability to think, act, and relate within the therapeutic context. The development of the person of the therapist, and his resolution of familial issues, is integral to successful treatment outcome.

(p. 98)

Various studies have addressed therapist family of origin experiences. These include parentification/infantilization (Lackie, 1980), nurturance/lack of nurturance (Racusin, Abramowitz, & Winter, 1981), and early childhood recollections (Harris, 1975). Additionally, the quantitative literature has inquired into the therapist's family of origin (Menninger, 1957; Burton, 1963; Henry, Sims, & Spray, 1973).

One issue not sufficiently addressed is that of the influence of loss/transition events in the family of origin of the therapist. In addition to the normative events that occur regularly in most families, i.e., marriage, birth of children, child entering school, child leaving home, there are certain paranormative events that affect the development of the family and, of course, the development of the individual within the family. Such events as illness, marital separation/divorce, household relocation, socioeconomic changes, or death have far-reaching effects on the family. Bradt (1980) discusses the importance of these "nodal events":

Nodal events are the usual happenings of family life that create instability in membership and/or function in the family system, events that bring up the possibility of loss or gain of membership and challenge the integrity and growth of the family unit. (p. 122)

Additionally, certain events that may not be considered nodal, in that they are not usual or normative experiences (i.e., substance abuse, physical/emotional abuse, or the institutionalization of a family member), also have profound influence on family and individual development for they involve the loss of relationship. As with nodal events, these relationship-loss events become focal points for

structural alteration in families along the lines of boundary change, communication patterns, and differentiation levels. Family homeostasis is disrupted and members take steps, functional or dysfunctional, in order to restore equilibrium. The time at which these events occur in an individual's life as well as in the family's life determines, in part, the effect that such losses may have on the individual. Therefore, the present study will investigate various nodal events as they occurred in the families of origin of family therapists.

However, investigation of the relationship between such factors as personality and family of origin and theoretical orientation within the family therapy field has been very limited. Kolevzon and Green (1985) studied the areas of convergence and divergence of practice among practitioners of three of the major models of family therapy. Using a sample of 156 American Association for Marriage and Family Therapy (AAMFT) therapists, these researchers investigated personality factors, the strength of orientation to a specific family therapy model, current practice activities, and belief and action systems. In a similar study using a sample of 1,451 AAMFT and American Family Therapy Association (AFTA) therapists, Kolevzon and Green (1985) focussed especially on areas of convergence and divergence from the theoretical orientation espoused by the

respondents. An as yet unpublished study for the Virginia Department of Corrections (Winter, 1987) will examine, among other characteristics, the family background and experience of family therapists across the same three models of family therapy used in the Kolevzon and Green study.

There remain numerous other factors associated with theoretical orientation across the family therapy field which merit inquiry. It was the purpose of the present study to explore and describe certain psychosocial characteristics of therapists according to several theoretical orientations within the field of family systems therapy. These characteristics include psychological type, personality factors, and the occurrence of loss events in the family of origin. The theoretical orientations in the field of family systems therapy which are used are: Virginia Satir's Process model, Salvador Minuchin's Structural model, and Murray Bowen's Systems model.

Theoretical Rationale

Among the psychological characteristics that may contribute to the embracing of a theoretical orientation is one's psychological type, or a combination of attitudes and preferred way of functioning, as proposed by Carl G. Jung (1933, 1971) and operationalized by Katherine C. Briggs and her daughter, Isabel Briggs Myers (1980), in the Myers-

Briggs Type Indicator. According to Jung (1971), there exist among individuals certain characteristic ways of perceiving and acting in the world that are peculiar to one's "type":

In my particular medical work with nervous patients I have long been struck by the fact that besides the many individual differences in human psychology there are also typical differences. Two types especially became clear to me; I have termed them the introverted and the extraverted types. (p. 3)

Introversion was conceptualized by Jung as the inner libido which withdraws from the outer world (away from objects) into self. Extraversion he described as the outer libido which moves toward objects, or, away from self. These "attitude functions" are present in all persons but Jung believed that individuals exhibit habitual use of one or the other of these functions and so are typed as "introverted" or "extraverted."

However, Jung (1971) recognized that this convenient means for distinguishing between two rather large groups of people was insufficient for describing the unique psychological processes that make up an individual. Therefore, he proposed that the attitude functions of

extraversion-introversion could be further differentiated according to "function types": thinking, feeling, sensation, and intuition.

- Thinking is that "which, following its own laws, brings the contents of ideation into conceptual connection with one another" (p. 481).

- Feeling, a subjective process, is described as "primarily a process that takes place between the ego and a given content, a process, moreover, that imparts to the content a definite value in the sense of acceptance or rejection ('like' or 'dislike')" (p. 434).

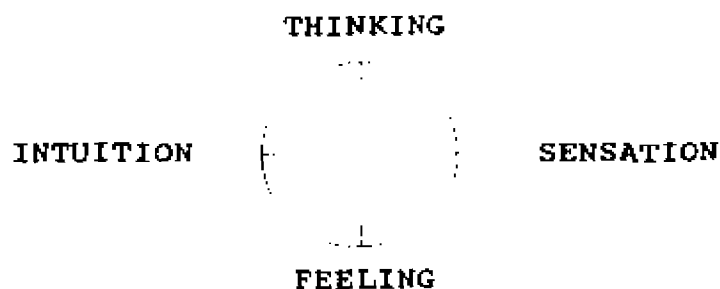
- Sensation "mediates the perception of a physical stimulus. It is, therefore, identical with perception" (p. 461).

- Intuition "mediates perceptions in an unconscious way is a kind of instinctive apprehension, no matter of what contents" (p. 453). A person's psychological type, therefore, consists of their attitude function (extraversion or introversion) along with one of the function types (thinking, feeling, sensation, and intuition) which are considered dominant in the personality.

Thus, Jung theorized eight psychological types delineated by the preference for one of the two attitude types plus a preference for one of the four function types. The eight psychological types include: the Extraverted

Thinking type, the Extraverted Feeling type, the Extraverted Sensing type, the Extraverted Intuitive type, the Introverted Thinking type, the Introverted Feeling type, the Introverted Sensing type, and the Introverted Intuitive type.

Jung (1971) conceived of the function types as bi-polar and further classified them as rational functions (thinking and feeling) and irrational functions (sensation and intuition). However, Jung recognized that the exhibition of the dominant function type did not preclude the presence of the less dominant function type, which "is invariably present in consciousness and exerts a co-determining influence" (p. 405). Indeed, the less dominant, or auxiliary, process provides balance in the personality. Therefore, if the dominant function is in either of the rational functions of thinking or feeling, then there is an auxiliary process in the irrational functions (sensation or intuition). The polarity of these functions can be conveniently conceptualized as:



Katherine Briggs and her daughter, Isabel Briggs Myers (1962, 1982) developed the Myers-Briggs Type Indicator (MBTI) as an extension of Jung's theory of psychological type. A major factor in this extension was their recognition that the auxiliary function has a far greater importance in describing an individual's type than Jung originally postulated:

Nowhere in Jung's book (Psychological Type) does he describe these normal, balanced types within an auxiliary process at their disposal. He portrays each process in sharpest focus and with maximum contrast between the extraverted and introverted forms; consequently, he describes the rare, theoretical "pure" types, who have little or no development of the auxiliary. (Myers, 1980, p. 17)

According to Myers, the auxiliary function allows for balance and supplementation of the dominant process with the less preferred process. Thus, "if the dominant process is perceptive, the auxiliary process will be a judging one: either thinking or feeling can give continuity of aim" (1980, p. 12).

In expanding Jung's original theory to include more emphasis on the auxiliary process, Myers doubled Jung's eight psychological types to sixteen psychological types,

which are formulated on four bi-polar scales: introversion-extraversion (I-E), intuition-sensing (N-S), thinking-feeling (T-F), and judging-perception (J-P). Thus a person's psychological type, according to Myers, consists of the individual's preference for one of the two polar processes on each of the four bi-polar scales. Myers, in the MBTI, uses a type formula to designate what preferences an individual exhibits. Four letters specify the preferences in such a way as to reveal their interrelatedness. The sixteen psychological types include:

Introverted Sensing types with Thinking as auxiliary
(ISTJ)

Introverted Sensing types with Feeling as auxiliary
(ISFJ)

Introverted Thinking types with Sensing as auxiliary
(ISTP)

Introverted Feeling types with Sensing as auxiliary
(ISFP)

Introverted Intuiting types with Feeling as auxiliary
(INFJ)

Introverted Intuiting types with Thinking as auxiliary
(INTJ)

Introverted Feeling types with Intuiting as auxiliary
(INFP)

Introverted Thinking types with Intuiting as auxiliary
(INTP)

Extraverted Sensing types with Thinking as auxiliary
(ESTP)

Extraverted Sensing types with Feeling as auxiliary
(ESFP)

Extraverted Thinking types with Sensing as auxiliary
(ESTJ)

Extraverted Feeling types with Sensing as auxiliary
(ESFJ)

Extraverted Intuiting types with Feeling as auxiliary
(ENFP)

Extraverted Intuiting types with Thinking as auxiliary
(ENTP)

Extraverted Feeling types with Intuiting as auxiliary
(ENFJ)

Extraverted Thinking types with Intuiting as auxiliary
(ENTJ)

The Jungian theory of psychological type and the Myers-Briggs Type Indicator provide a means for understanding the ways that individuals prefer to relate, perceive, and make judgements about the world. As such, the factors delineated would assist in investigating various therapist characteristics associated with diverse theoretical orientations.

Definition of Terms

Family of origin. The unit of primary relationships into which an individual is born. This includes parents and siblings as well as the extended familial network of aunts, uncles, grandparents, and cousins. While the family of origin is usually considered the network of blood relationships, adopted persons may count their adoptive families as their families of origin if their primary familial experience is with that adoptive family. The term "family of origin" also implies familial traditions, ethnicity, regional associations, and religious identifications associated with a particular family's history.

Family systems therapy. A type of psychotherapy in which client issues are viewed in the context of the familial network. The focus of intervention, then, is in the family unit, or family system. Treatment may consist of re-structuring family patterns, altering communication sequences, re-aligning subgroups, or enabling differentiation from the family depending on the specific model of family therapy being used. Often the entire family participates in therapy sessions, or one member or a subgroup (e.g., spouses, siblings) may participate. An

abbreviated term for family systems therapy, family therapy, is used in the present study.

Loss/transition events. In addition to the normative events that occur regularly in most families, i.e., marriage, birth, child entering school, there are certain paranormative events that affect the development of the family and, of course, the development of the individual within the family. Those events involve some sort of loss or transition. This includes the more obvious events such as death, household relocation, marital separation/divorce, or serious/handicapping conditions. Additionally, other events that commonly occur in many families, but are not necessarily "normative", include substance abuse, physical/emotional abuse, or institutionalization of a family member. These also are considered loss/transition events since they involve the loss of relationship, or, at the least, some transition in the nature of relationships.

Personality characteristics. Personality is defined by Byrne & Kelly (1981) as "the sum total of all of the relatively enduring dimensions of individual differences" (p. 33). Those dimensions are the "characteristics" which enable us to describe ourselves and our behavior. Instruments which measure personality are designed to describe persons according to "motivational, interpersonal,

and attitudinal characteristics, as distinguished from abilities" (Anastasi, 1976, p. 493).

Typology, psychological type. The attitudinal and functional preferences of an individual according to the theory of types developed by Carl Jung and expanded by Katherine Briggs and Isabel Briggs-Myers. A person's "type" consists of one's preference for one of two polar processes on each of four bi-polar scales: introversion-extraversion, intuition-sensing, thinking-feeling, and judging-perception. One's "type" is commonly expressed according to letter designations based on the Myers-Briggs Type Indicator. Therefore, an "INTJ" refers to an individual whose preferences in dealing with the world are for introversion over extraversion, intuition over sensing, thinking over feeling, and judging over perception. Individuals are also described according to "type" by labeling them according to their preference for one of the bi-polar scales. For example, a person whose preference is for intuition rather than sensing would be described as an "Intuitive type."

Research Hypotheses

The specific hypotheses to be investigated include:

1. Are there differences among family therapists from the three theoretical orientations with regard to psychological type?

2. Are there differences among family therapists from the three theoretical orientations with regard to personality characteristics?
3. Are there differences among family therapists from the three theoretical orientations with regard to the occurrence of loss events in their family histories?

Sample and Data-Gathering Procedures

The purpose of this study was to investigate certain psychosocial characteristics of family therapists according to different theoretical orientations. These characteristics include: typology, personality characteristics, and loss/transition events in family of origin experiences.

The sample for the present study was drawn from therapists across the United States and Canada representing three different theoretical orientations within the family systems therapy field. These include the Process model (Virginia Satir), the Structural model (Salvador Minuchin), and the Systems model (Murray Bowen). Since the intent of the study was to investigate the psychosocial characteristics of therapists according to certain known theoretical orientations, participants were selected by major advocates of each model on the basis of their training

in and reflection of the principles of that model. A sample of 184 family therapists was selected: 64 from the Process model, 60 from the Structural model, and 60 from the Systems model.

The Myers-Briggs Type Indicator (Myers & McCaulley, 1986), the Adjective Check List (Gough, 1980), and a Nodal Events Survey (prepared by the researcher) were mailed to participants. A Therapist Information Form specifically prepared for this study was also included.

Limitations of the Study

Several factors are noted in discussing the generalizability of the conclusions drawn from this study. First, the small n should be considered when reviewing the results. Second, all data is based on self-report instruments. There is always some caution in interpreting results from self-report because of the inherent bias of the participants. Thirdly, the selection of participants by major advocates of each model, while assuring their representation of "true" model interpretation according to that advocate's own standards, may be compromised. Unintentional bias in the selection of participants should thus be considered.

Ethical Considerations

The personal nature of the responses by study participants was noted. The Nodal Events Survey, especially, requests information concerning family events such as substance abuse and institutionalization. All participants were assured of complete confidentiality. In order to safeguard identities, instruments were coded so as to prevent recognition of names. The matching of codes and names occurred only in preparing the instrument package for mailing and upon receipt of returned instruments. The list matching codes with names was destroyed after data were prepared for calculation.

Participants were given the opportunity to request a summary of the results of this study. Individual results based on responses to the instruments were provided when requested.

Chapter 2: Review of Related Literature

The areas of investigation are presented in two sections. First, a review of the development of the family therapy movement and description of the family therapist's role and training. Second, a review of the status of relevant research in Jungian typology, personality characteristics, and family of origin factors.

Development of the Family Therapy Movement

Diverse fields of inquiry, fortunate relationships, the utilization of established organizations, and a drive to publish findings account for the amazing cross-fertilizing of ideas and personalities that gave birth to the family therapy movement in the United States. Histories of the movement (Sager, 1966; Jackson & Satir, 1968; Guerin, 1976; Kaslow, 1980; Broderick & Schrader, 1981) credit anthropology, social psychology, sociology, biology, botany, cybernetics, psychiatry, communications theory, and hypnosis as contributing in various ways to the conceptualization of the family unit, rather than the individual, as the locus for psychological observation and treatment. Theorists and practitioners, expanding the ideas of their original

teachers, exchanged ideas, and collaborated on a myriad of projects in pursuit of new approaches to treating schizophrenia, marital problems, severe physical illness, delinquency, and psychosomatic disorders. Additionally, forums for sharing ideas were provided by established organizations (e.g., American Orthopsychiatric Association) and publications (e.g., American Journal of Orthopsychiatry).

While most of the historians of the family therapy movement place its origins in the 1950s, the thread of its development actually must begin with the first clinician, Sigmund Freud. Freud recognized the influence of the parent-child relationship on an individual's development, clearly seen in the case of Little Hans (Freud, 1909), but he continued to emphasize, instead, factors within the individual rather than interpersonal factors. According to Broderick and Schrader (1981), Freud did attempt the simultaneous analysis of a husband and wife, James and Alex Strachey (who later became English translators of Freud's works), but found the effort nonproductive: "our efforts remain fruitless and are prematurely broken off because the resistance of the husband is added to that of the sick wife. We had only undertaken something which, under the existing circumstance, was impossible to carry out" (Freud, 1915/1935, p. 398). Freud, and members of the

psychoanalytic community for years to come, found the problems of confidentiality, impartiality, multiple transference, and countertransference when treating families to be so profound that they virtually excluded any family member from the treatment of a client (Kaslow, 1980). An early opinion is most telling of Freud's stance: "As regards the treatment of their relatives, I must confess myself utterly at a loss, and I have in general little faith in any individual treatment of them" (Freud, 1912/1958, p. 120). Thus, Freud set the precedent in the psychoanalytic movement for ignoring the family in favor of concentrating on the inner needs and drives of the individuals.

Nevertheless, the realm of interpersonal relationships became a focus for ensuing departures from Freud's beliefs and practices. In 1921 Flugel, in The Psycho-Analytic Study of the Family, predicted that departure:

It is probable that the chief practical gain that may result from the study of the psychology of the family will ensue more or less directly from the mere increase in understanding the nature of, and interactions between, the mental processes that are involved in family relationships. (p. 217)

Other personality theorists followed in the investigation of social and family influences. Alfred Adler's work (1930, 1931, 1938) underscored the inherently

social nature of human beings and examined the influence of psychological birth position on children. Jung's concept of the mask (persona), which persons utilize in response to the demands of society and its conventions, recognized the influence of others in shaping human response (1910, 1945). Additionally, there was Karen Horney's notion of basic anxiety in children as being a product of the parent-child relationship (1937, 1945). Fromm turned his attention to the isolation and separation that human beings encounter in their relationship with nature and with other human beings (1941, 1947). Clara Thompson's work emphasized the influence of social, cultural, and family relationships on personality development (Slipp, 1984). These theorists effectively promoted the importance of examining the interpersonal as a means of understanding the individual.

Perhaps one of the most influential of the personality theorists on the development of family therapy, especially as regards his influence on Don D. Jackson, is Harry Stack Sullivan (Slipp, 1984). A basic tenet of his interpersonal theory of psychiatry is that one cannot study an individual apart from his/her relationships with other people; therefore, the correct unit for study is the network of social interactions which include the individual (Sullivan, 1927, 1953). Additionally, Sullivan's work on tension and anxiety as they arise and exert influence within the

individual and, in systematic fashion, on his/her relationships, underscores the importance of considering one's relationships (e.g., family) as a means for understanding the individual.

Thus, with the field broadened from Freud's narrow emphasis on individual instincts and motivations to recognition of the influence of interpersonal relations on development, the step toward consideration of treating the family (rather than the individual alone) was inevitable. The child guidance movement provided a format for investigating the family in the standard practice of the psychiatrist seeing the disturbed child while the social worker saw the family. This procedure was expanded to include adult patients and their families (Bowen, 1978; Jackson & Satir, 1968).

Several clinicians and theorists in the United States began to address families as a unit for treatment, especially in the area of schizophrenia. In 1937 child psychiatrist Nathan Ackerman (who as an analysand of Clara Thompson), while at the Southard School in Topeka, Kansas, began seeing whole families and sending his staff to patient's homes to observe the families (Guerin, 1976). Ackerman and Sobel wrote "Family diagnosis: An approach to the pre-school child" (1950) in which they advocated an understanding of family processes in order to understand the

young child. Theodore Lidz, also a psychiatrist, began working with families of schizophrenics in the 1940s while at Johns Hopkins. In 1946, Carl Whitaker, as Chief of Psychiatry at Emory University in Atlanta, focussed on the families of schizophrenics. Murray Bowen, from 1949 to 1954, studied mother-child symbiosis with schizophrenic children at the Menninger Clinic in Topeka. In 1954 Bowen joined Lyman Wynne at the National Institute for Mental Health (NIMH) near Washington, D.C. where whole families with schizophrenic members were hospitalized. In this project individual sessions were dropped entirely in favor of the more productive family treatment (Bowen, Dysinger, Brodey, & Basamania, 1957). Additionally, Bowen et al. reported the fluctuating and complementary nature of symptoms observed in families as interactions take place. Another research project on schizophrenic families was begun at the Eastern Pennsylvania Psychiatric Institute (EPPI) in 1958 with Ivan Boszormenyi-Nagy, psychologists James Framo and Gerald Zuk, and social worker Geraldine Spark (Kaslow, 1980). Additionally, Midelfort, working in Wisconsin, published his findings on treating schizophrenics and the families in The Family and Psychotherapy (1957). Midelfort concluded that all mental illness develops in the family.

In California in 1952 anthropologist Gregory Bateson assembled a research team whose eventual focus was

schizophrenia. Bateson's interest in communication theory (Reusch & Bateson, 1951) set the direction for the project in which the paradoxes of abstraction were studied. The individuals whom Bateson brought together became known as the Palo Alto Group and included John Weakland, William Fry, Jay Haley, and Don Jackson. Haley, who was interested in film analysis, was greatly influenced during the project's development by hypnotherapist Milton Erickson and enlarged the investigation of paradoxical material with regard to schizophrenic families. Don Jackson, a psychiatrist, had done some work on family homeostasis while at Chestnut Lodge studying with Harry Stack Sullivan and Frieda Fromm-Reichmann (1957). The Bateson team worked intensively with families with schizophrenic members, instituting the use of the one-way mirror in family treatment (Simon, 1982). In 1956 Bateson, Jackson, Haley, and Weakland published "Toward a theory of schizophrenia," a hallmark article which introduced the "double-bind" concept as a common occurrence in families with schizophrenic children. This concept described communication in these families as existing on several levels that could conflict and, paradoxically, prevent an acceptable response (Haley, 1980). The work of the Palo Alto Group provided the developing family therapy field with the language of and emphasis on communication and meta-communication within families (Lipset, 1980).

Meanwhile, several clinicians were investigating the idea of family treatment in other areas. Virginia Satir, a social worker, had begun formulating ideas about treating families while working with delinquent girls and, later, in private practice in Chicago. She also taught a course in family dynamics to medical residents at the Illinois State Psychiatric Institute (Satir, 1982). Lyman Wynne, before going to NIMH, had seen whole families as part of the treatment process of severely physically ill patients at Massachusetts General Hospital in 1947 (Broderick & Schrader, 1981). Carl Whitaker, in private practice in Atlanta, was seeing couples in what he called "dual therapy."

In 1955, 1956, and 1957, Wynne, Bowen, Jackson, Ackerman, and Lidz met and began exchanging views. Nathan Ackerman chaired the first session on family diagnosis held at a meeting of the American Orthopsychiatric Association in 1955, and this was followed later in the year by a panel discussion at a meeting of the American Psychiatric Association. A direct outgrowth of this interaction was the exchange of videotapes of family counseling sessions between Don Jackson and Lyman Wynne in 1959 (Jackson, Riskin, & Satir, 1961). Ackerman opened the Family Mental Health Clinic in New York City in 1957 and published the first full-length description of theory and practice in the family

therapy field, Psychodynamics of Family Life, in 1958. In the same year Whitaker published an account of his dual therapy, "Psychotherapy with Couples," (Whitaker, 1958). Jackson, as editor, brought together much of the research on family therapy with schizophrenia in 1960 with publication of The Etiology of Schizophrenia.

In 1959 Don Jackson coined the term "conjoint family therapy" to describe a therapist meeting together in the same session with a husband and wife, in an article entitled "Family Interaction, Family Homeostasis, and Some Implications for Conjoint Family Therapy." Jackson also, in that same year, founded the Mental Research Institute in California, along with Virginia Satir and Jules Riskin. They were joined later by Jay Haley (1962) when the Bateson Project was terminated. The first formal training program in family therapy was devised by Satir while at the Mental Research Institute (Satir, 1982). The contribution of the Mental Research Institute team lies primarily in developing a "systems" approach to family therapy (Jackson, 1968).

Meanwhile, Nathan Ackerman had established the Family Institute in New York City (later to be renamed the Ackerman Institute, following his death). Another hallmark in the family therapy movement was reached in 1961 with the founding of the first family therapy journal, Family Process. The journal was jointly sponsored by Ackerman's

Family Institute and Jackson's Mental Research Institute and "has been the chief unifying influence in the movement ever since" (Broderick & Schrader, 1981, p. 25). Jay Haley was named as the first editor of Family Process.

Virginia Satir, influenced by the Palo Alto Group, but bringing her own experience and views to the family therapy movement, published her first book, Conjoint Family Therapy, in 1964. This book, different from other family therapy publications in its deliberate non-technical format, is indicative of family therapy's movement into the more broad-based realm of the non-psychiatric, psychotherapy community. Satir became involved in the human growth movement of the mid-60s and left the Mental Research Institute to become director of training at the Esalen Institute in Big Sur, California. In 1972 she published Peoplemaking, a discussion of family process aimed at non-professionals. Her model, referred to as Process Model (Satir, 1982) and later and the Human Validation Process Model (Satir & Baldwin, 1983), is a systemic model emphasizing communication, self-worth, and holism (Bitter, 1987). Satir also has stressed the person of the therapist as integral to the practice of family therapy (Satir, 1987). The Avanta Network was founded by Satir as a non-profit educational organization composed of human service professionals who receive regular training from Satir.

Salvador Minuchin, a psychiatrist and native of Argentina, originally worked with delinquent children at the Wiltwyck School for Boys in New York in the early 1960s. With the publication in 1967 of his book, Families of the Slums, Minuchin launched the family movement into a focus on treating urban slum families (Broderick & Schrader, 1981). Minuchin became director of the Philadelphia Child Guidance Clinic (PCGC) in 1967 and assembled a diverse staff to develop and implement a new approach to family therapy. Jay Haley, originally with the Palo Alto Group and the Mental Research Institute in California, joined Minuchin in Philadelphia. Braulio Montalvo and Bernice Rosman also joined Minuchin, followed later by Harry Aponte, a social worker, and child psychiatrist Ron Leibman. The Structural model devised by Minuchin and his colleagues was specifically devised to assist low-socioeconomic families. The emphasis in this approach is one of re-structuring family boundaries, alignments, and hierarchies so as to eliminate dysfunctional patterns. Utilization of videotape, direct supervision, and team supervision are several of the methods developed at the Philadelphia Child Guidance Clinic and later widely adopted in the family therapy movement (Broderick & Schrader, 1981). Minuchin also found his approach particularly helpful with anorexia nervosa patients

(Minuchin, Rosman, & Baker, 1978) and, recently, has reached out to a more general readership in Family Kaleidoscope (1984).

Murray Bowen moved from NIMH to an association with Georgetown University School of Medicine where he became head of the Family Center in Washington, D.C. He investigated the difficulties associated with an individual "differentiating" him/herself from his/her family of origin. Thus the theory which he developed, called Bowen Theory, examines multi-generational patterns of family functioning. In 1972 Bowen's publication of his work in understanding his own family of origin according to Bowen Theory focused the attention of the family therapy movement on the person of the therapist (Anonymous, 1972). Bowen and his followers continue to advocate the importance of the therapist understanding his/her own multi-generational history. In 1978 Bowen published a collection of his works, Family Therapy in Clinical Practice.

By 1976 Jay Haley had left the Philadelphia Child Guidance Clinic and, together with his wife, Cloe Madanes, established the Family Therapy Institute of Washington, D.C. Madanes, originally from Argentina, had studied at the Mental Research Institute and was hired by Minuchin to work at PCGC as a supervisor and trainer (Simon, 1986). Haley and Madanes together have refined a model of therapy,

Strategic family therapy, which utilizes paradoxical techniques and strategic interventions. Haley, a prolific author, has contributed significantly to the literature of the field. Additionally, Haley is recognized as a primary interpreter of Milton Erickson's work (Haley, 1973).

Lothar Salin has observed that the original family therapy pioneers (all from psychiatric training) found their investigations of individual and schizophrenia "spilled over" into marriage counseling (Salin, 1985, p. 37). Increasingly the two fields overlapped and, to reflect that merging of interests, the American Association of Marriage Counselors became the American Association of Marriage and Family Counselors in 1970. In 1978 the name was changed to the American Association for Marriage and Family Therapy (AAMFT). Another organization, the American Family Therapy Association (AFTA) was formed in 1977 (with Murray Bowen as president) in order to encourage more research in the field.

Attempts to classify the family therapy field began with Jay Haley's tongue-in-cheek caricatures of leading innovators in a 1962 issue of Family Process. There followed a report from the Committee on the Family of the Group for the Advancement of Psychiatry (GAP) in 1970 that included a survey of the field of family therapy between 1965 and 1966. The GAP report identified three theoretical positions: Position A, in which the therapist is

individually-oriented and sees families or family members as an adjunct to individual therapy; Position Z, in which the therapist is oriented to the family exclusively, not as an adjunct to individual work, but, rather, as a whole new conceptualization of mental health; and Position M, which includes the therapist somewhere between the two extremes of Positions A and Z.

Beels and Ferber (1969) examined the personality styles of the leading therapists, rather than the theory of family systems, in developing their classification of the field. They classified therapists as either "conductors", therapists who dominate a session and actively lead the process; or as "reactors", therapists who respond more to the peculiar processes that emerge within a family. Notably, Virginia Satir, Murray Bowen, and Salvador Minuchin were seen as conductors, while Jay Haley was classified as a reactor.

Foley (1974) tried to synthesize the GAP report and the Beels and Ferber classification, thus highlighting the continuing debate in the field as to interpersonal (systems) vs. individual (analytic) orientations and active vs. observant stances among therapists. Guerin (1976) attempted to develop a comprehensive classification from the GAP report. His work again reveals the state of the family therapy field: the individually-oriented family therapist

(the GAP report's Position A), family group therapy (Wynne, 1974), the experiential subgroup (Whitaker) Ackerman-type approaches, and a systems group (The GAP report's Position Z). The systems orientation included four subgroups: communication-systems family therapy (Satir, Haley), structural family therapy (Minuchin), Bowenian family systems theory (Bowen), and general systems thinking.

In the 1970s it was apparent that two distinct generations of thought in family therapy had evolved: a homeostatic model and an evolutionary model (Hoffman, 1981). The homeostatic model, which notes the equilibrium-maintaining qualities of interactions and behaviors in families, sprang from the work of Don Jackson and his associates (including Haley and Satir) at the Mental Research Institute in California. The evolutionary model emphasizes the sudden transformations that come about in living systems as a process of "evolving, nonequilibrium entities" (Hoffman, 1981, p. 5). This model, often called the "epistemological approach", originating from Bateson's work in Palo Alto, has been supplemented by work being done in physics, biology, and general system theory. It has been interpreted in the family therapy community by Rudolph (1980), Dell (1981). Hoffman, Virginia and Bradford Keeney at the Ackerman Institute (Hoffman, 1981), and the Milan Associates from Italy (Palazzoli, 1974, 1978).

A more recent classification of the family therapy field is Levant's (1984) attempt using the variables of time perspective, focus of therapeutic change, role of the therapist, duration of therapy, and principal theoretical background as delineating factors. Based on these categories, Levant characterized three therapeutic models of family therapy; historical, structural/process, and experiential.

The historical model, which includes Murray Bowen's multigenerational approach (Systems model), concentrates on the past. Here, the present difficulties in a family, or in an individual, are framed with reference to the mental health of the preceding generations. Therefore, the focus of therapeutic change is on freeing persons from certain patterns and attachments of past generations. This is accomplished mainly through encouraging insight into excessive attachments and providing support to disengage from them. The therapist's role is to coach individuals as they attempt to differentiate from their families. This role is more interpretive and less active than other family therapy models. The duration of therapy is long-term and the principal theoretical background, beyond Bowen Theory, is psychoanalysis (Levant, 1984).

The structure/process model, which includes Minuchin's Structural family therapy, is oriented to the present,

including the history of the presenting problem and the near future when the present problem is resolved. The focus in Structural family therapy is to change the structure of the family which creates and maintains dysfunctional behavior (Aponte & VanDeusen, 1981). Attention centers on system boundaries, subsystems, alignments, coalitions, patterns of adaptation, and transitional points within the family. Change is brought about by direct intervention into the family system during the session, often followed by homework assignments designed to emphasize whatever structural change was initiated within the session (Minuchin, 1974). The therapist's role is, therefore, very active and directive of the process in which patterns are changed. The therapy is considered short-term and its background is systems theory and learning theory (Levant, 1984).

The experiential model, which includes Satir's Process approach, is oriented to the present and to the past only as a means for dealing with the present. The focus for therapeutic change is on intensifying the affective experience for family members so that they may reconnect to one another (Levant, 1984). The Process model emphasizes the congruency or incongruency of messages exchanged on a metacommunicative level, thus stressing the feeling aspect of communication in relationships (Foley, 1974). Additionally, Satir emphasizes self-worth and how impairment

of that self-worth creates incongruent and dysfunctional patterns (Satir, 1967, 1972). The therapist's role is very active in promoting the reconnection of relationships and reflecting observed family process. Satir views the therapist as a teacher who fosters conditions for growth within the family (Foley, 1974). The duration of therapy is intermediate-term, depending on the situation. Levant characterizes the background of the experiential model as existentialism and phenomenology. However, communication theory, Ericksonian hypnosis, psychodrama, bio-feedback, general semantics, transactional theory, autogenics, Gestalt theory, and systems theory also have influenced Satir (Satir, 1982).

Currently, the family therapy movement is an established field of endeavor in the psychotherapeutic community. Its various models and techniques have been applied to the diverse challenges of today: family violence, incest, spouse abuse, teen-age pregnancies, the homeless (Walters, 1985), substance abuse (Coleman & Stanton, 1978), ethnicity (McGoldrick, Pearce, & Giordano, 1982), marital therapy (Gurman, 1985), chronic pain (Boll, DuVall, & Mercuri, 1983), and delinquency (Alexander, Barton, Schiavo, & Parsons, 1976). Numerous family therapy journals have appeared in the United States since the first, Family Process, in 1961, including the Journal of Marital and

Family Therapy, The Family, the Family Therapy Newtworker, Family Systems Medicine, the American Journal of Family Therapy, and the International Journal of Family Therapy.

Role and Training of Family Therapists

Since the present study centers on the characteristics of therapists from three different models of family therapy, it is appropriate to further address the role of therapists according to these specific models. Additionally, a description of the unique training approach characteristic of each model is provided.

The role of the therapist using the Bowen model is one of coach, teacher, and consultant as he/she assists clients toward the differentiation of self (Bowen, 1978; Singleton, 1982; Kerr, 1981). A deliberate effort is made by the therapist to maintain a neutral stance with clients. This encourages responsibility on the part of the client since it discourages over-responsibility on the part of the therapist (Singleton, 1982). Therapeutic activity is aimed at reducing anxiety, encouraging work with the extended family, and teaching principles of systems relationships.

A key element of the therapist role and training according to the Bowen model is the therapist's own work at self-differentiation. The better differentiated the therapist, the more he/she is able to remain objective and

available to the family (Singleton, 1982). Therefore, continual work on differentiation, especially with one's family of origin, is a basic component of therapist training in the Bowen model. Trainees undertake this differentiating effort and receive clinical assistance in small group supervisory experiences.

The role of the therapist in Structural family therapy is to assist the family to restructure itself (Colapinto, 1982). The therapist actively joins the family system and uses his/her position within that system to alter the structure (Aponte & VanDeusen, 1981). The therapist may join with a particular coalition so as to alter the alignment in another part of the system. Thus, the Structural family therapist uses his/her relationship with the family and first members to affect change (Aponte & VanDeusen, 1981).

The skills demanded of a Structural family therapist include the ability to facilitate engagement or disengagement (Aponte & VanDeusen, 1981) with family members. Relationship skills are, therefore, important, since the therapist "becomes" a part of the system which he/she is seeking to change (Minuchin, 1974). Additionally, the therapist must be able to experience what it is like to be in a particular family, yet be sufficiently detached so as to observe and initiate intervention (Aponte and

VanDeusen, 1981). Colapinto has likened the Structural therapist's role to a dancer, a camera director, or a stage director in that he/she participates and gives direction at the same time (1982).

The Structural family therapist is not concerned with the person of the therapist. In fact, growth experiences are considered incidental to the model (Aponte & VanDeusen, 1981). Self-knowledge, as it might assist one to use personal relationship skills more effectively, is encouraged by not emphasized.

Training in Structural family therapy is aimed at teaching the trainee to recognize family structure as it occurs in a transaction, and to make interventions that will alter the transaction and, thus, the family's structure (Aponte & Van Deusen, 1981). Role-playing, live supervision, small group clinical training, and observation of video-taped sessions are commonly used training methods. The supervisory relationship reflects the attention to boundaries of the Structural model in that it is hierarchical and non-democratic (Liddle & Halpin, 1978). This method pairs a trainee with an expert clinician who guides the trainee in the development of skills (Weiner, 1972).

The role of the therapist in Satir's Process model of family therapy is that of the teacher and model. The

therapist teaches family members about the different levels and meanings of communication and demonstrates appropriate communication. In this manner, the therapist is a "resource person" for client families (Satir, 1967).

Satir's recognition of the importance of feelings and her emphasis on people connecting with one another on that feeling level requires the therapist to affectively experience the family as well (Satir, 1982; Levant, 1984). Touch, movement, role-playing, and sensory awareness are characteristic treatment procedures utilized by Process model family therapists in treating families (Satir, 1967; 1982).

In order to model affective connection and teach congruent communication skills, the Process model therapist must enter the client family and remain available to family members on a feeling level. Therefore, Satir encourages self-knowledge on the part of the therapist and emphasizes personal growth and enhancement (Satir, 1987). Such self-knowledge assists the therapist to keep separate his/her own difficulties from those of the client and to recognize his/her own vulnerability as a fellow human being (Satir, 1987).

Despite the shared systems orientation in treating families, therapist role and training programs vary among the three models discussed here. The Systems model presents

the therapist as a consultant to the client or client family who, although maintaining a neutral stance, provides insight and support. The Structural model therapist actively joins the family system and uses his/her place to restructure the whole. The therapist from Satir's Process model is actively in relationship with the client family, models congruent communication, and encourages affective connection among family members.

The training and supervisory programs of the various family therapy models are, likewise, quite different. Liddle and Halpin (1978) have pointed out that the training programs of the Systems and Process models of family therapy emphasize the affective lives and personal growth and awareness of the trainees. In contrast, the training programs of the Structural model of Minuchin are aimed at developing therapist skills and cognitive intervention style.

Research on Typology, Personality, and Family of Origin

The following section continues the review of literature. The variables of typology, personality characteristics, and family of origin factors among therapists are investigated.

Typology

A number of studies have used the Myers-Briggs Type Indicator (MBTI) to examine the typological characteristics of therapists. Results have been reported in terms of the four bi-polar dimensions of Extraversion-Introversion, Intuition-Sensing, Thinking-Feeling, and Judging-Perception. The target populations have included therapists from various kinds of orientations working in diverse settings. However, none of these studies have included family therapists among their samples.

A study by Perry (1975) investigated the typological differences between experimental and clinical psychologists. Using a sample of psychologists ($N=72$) from these fields and including a buffer group of psychologists with interests in both areas, Perry found that a majority of the psychologists were Intuitive types. Moreover, he found that there were proportionally more Sensing types among the experimental psychologists (33%) than among the clinical psychologists (only 4%).

Levin's (1978) study focussed on the typological differences among therapists of five different theoretical orientations: behavioral, Gestalt, psychoanalytical, rational-emotive (RET), and experiential. An ANOVA statistical procedure with a sample of 91 psychotherapists

was utilized. A high occurrence of Intuitive types among psychotherapists across the orientations was again reported. Additionally, Levin found differences on the other bi-polar dimensions among the therapists of various orientations: RET, experiential, and behavioral therapists tended to be more Introverted; whereas, the Gestalt and psychoanalytic therapists were more often Extraverted. On the Thinking-Feeling dimension, behavioral and RET therapists were more often Thinking types and the experiential, Gestalt and psychoanalytic therapists were most often Feeling types. Gestalt and experiential therapists were characterized as Perceptive types while behavioral, RET and psychoanalytic therapists were Judging types.

Other studies lend support to the frequency of Intuitive types among psychotherapists. Galvin (1975) investigated 42 professional and para-professional counselors with regard to Jungian typology and Rogerian facilitative conditions. He reported that 95% of the entire sample were Intuitive types. Buchanan and Bandy (1984) examined the typologies of therapist applicants for training in psychodrama and reported 84% of the 37 applicants were Intuitives. Hanewicz (1978) and Myers (1980) described the common occurrence of Intuitive-Feeling types in the counseling professions (i.e., social work, psychiatry, clinical psychology) and among college level counseling

students. Durfee (1971), in studying the typologies of students in the helping professions, found not only a majority of Intuitive types, but also found that social work students tended to be Intuitive-Feeling types and psychology students tended to be Intuitive-Thinking types. In a study of secondary school counselors, Levell (1965) found, in addition to the characteristic Intuitive type profile, that those counselors judged most effective were Intuitive-Feeling types. Additionally, Levell reported that 73% of his sample were Extraverts.

Perelman (1977) employed a phenomenological methodology using the MBTI and structured interviews with a sample of eight Masters degree students in counseling education. All eight counseling students were Intuitive types; four were Intuitive-Feeling types and four were Intuitive-Thinking types. Perelman found sufficient evidence to state that the Introverted-Feeling types were more attuned to the quality of the client-counselor relationship; whereas, the Introverted-Thinking types were more intrigued by the distinctive behavior patterns exhibited by their clients.

Witzig (1976) investigated the typologies of 102 professional mental health counselors working in public health clinics in Oregon. He found over half of this sample

were Extraverted types and just under half were Intuitive types (only 8% were Sensing types, the opposite of Intuitive types).

Several studies with non-therapist samples provide assistance in understanding how psychological type influences the manner in which people operate in the certain situations. Kerin and Slocum (1981) used the MBTI with a sample of business administration graduate students ($n=40$) who were all Intuitive types (the most common type for therapists). In an investigation of preference for solving an unstructured business problem, they reported that the Intuitive-Thinking types preferred more objective, quantitative data than the Intuitive-Feeling types. This study underscores the Perelman (1977) finding that Intuitive-Thinking type therapists were more attuned to behavioral patterns (more objective and quantitative) in the clients while the Intuitive-Feeling types were more interested in the quality of the client-counselor relationship.

An exploratory study by Kilmann and Thomas (1975) examined the relationship between psychological type and conflict-handling modes. Although the sample was a group of graduate students ($n=96$) in a behavioral science management course, the subject under investigation is most pertinent since conflict management is frequently a problem of

psychotherapeutic practice. Kilmann and Thomas focussed on the judging and enactment aspects of conflict-handling by using the Extraversion-Introversion and Thinking-Feeling dimensions of the MBTI. Their findings revealed that Feeling types were more accommodating in conflict-handling behavior than Thinking types, and Extraverted types more often looked for integrative solutions than Introverted types. The suggestion that psychological type preferences influence the choice of conflict-handling modes may have application in the psychotherapy field as regards those therapists who prefer theoretical orientations which use accommodation or integration as opposed to more confrontative methods in conflict-handling situations.

The aforementioned research literature documents the frequent preference of the Intuitive type as characteristic of professional therapists as well as in populations of similar characteristics (i.e., counseling students). However, there appears to be no predominance of any of the other types associated with therapists. Rather, previous research findings demonstrate the differentiating ability of the other bi-polar dimensions among diverse theoretical orientations and settings in the field of psychotherapy. Orientations characterized by examination of the inner self and emphasis on the quality of the client-counselor relationship, such as experiential, psychoanalytic, or

Gestalt therapies, have therapists who are Feeling types; whereas, orientations characterized by cognitive activity using quantitative data, such as RET and behavioral therapy, have therapists who are Thinking types. Theoretical orientations which have a high tolerance and value for spontaneity, such as experiential or Gestalt therapies, have therapists who are Perceptive types as opposed to orientations that place a value on logic and planning, such as RET and behavioral therapies, which have therapists who are Judging types.

If the non-therapist sample studies are considered as giving clues to therapist preferences in terms of modes of handling conflict or ways of gathering information in problem-solving, then further differentiation of therapists by theoretical orientation can be made. The more confrontive psychotherapies, such as RET and behavioral therapies, will have therapists who are Thinking types as opposed to the more accommodating orientations, such as experiential or Gestalt, which have Feeling types. In summary, orientations which especially value the quality of the client-counselor relationship, such as psychoanalytic or experiential therapies, will have Feeling types as opposed to the therapists from orientations that value that relationship less in favor of observing and changing patterns, such as RET and behavioral therapy, which will

have Thinking types. Additionally, the research characterizes those working in mental health settings as Extraverted types, in social work settings as Feeling types, and in clinical (as opposed to experimental) settings as Intuitive types.

There are several problems with the research done thus far using the MBTI to establish Jungian typologies as descriptors of therapists. The samples are small, running from eight to 102 in this review. This would present a more serious problem if the usual method of portraying MBTI scores were used (showing combination of type preferences); most researchers use continuous scores, instead, to establish preferences for one or the other poles in the bipolar dimensions. While student samples are often used, a sufficient number of studies with experienced, professional psychotherapists are available (note studies by Galvin, Perry, Levin, and Witzig). Carkskadon's (1979) criticism that much of the MBTI literature does not address the issue of why some relationships are not significant is well taken. Additionally, the lack of replication studies noted by Carkskadon raises questions as to the soundness of the results reported thus far.

As noted previously, there is an absence of studies using the MBTI to establish psychological typology for family therapists. Since, despite the common thread of

systems theory, the family field represents diversity in theoretical orientation and clinical practice, establishment of typological characteristics of therapists representing the various orientations is in order.

Personality Characteristics.

Attempts at developing a description of therapist personality characteristics had already begun when Cottle surveyed the literature in 1953. At that point much of the research had been aimed at describing "successful" counselors and contrasting clinical with industrial psychotherapists. Cottle concluded that the research accumulated thus far was inadequate and suggested the use of interest inventories and standardized personality instruments to identify counselor characteristics in various areas and within various levels.

Following that lead, Freedman, Antenen, and Lister (1967) investigated the relationship between personality characteristics and verbal responses in an interview situation using the California Psychological Inventory (CPI) and the Guilford-Zimmerman Temperament Survey (GZTS). The researchers found that there was a strong, predictable relationship between counselor personality characteristics and verbal response patterns. Additionally, several characteristics commonly appeared in the counselors:

Responsibility (CPI), Sense of Well-Being (CPI), Dominance (CPI), Self-control (CPI), Flexibility (CPI), and Sociability (GZTS). However, Freedman et al.'s sample was very small ($n=37$) and consisted of counseling practicum students rather than practicing psychotherapists, so its generalizability is questionable.

Kassera and Sease (1970) studied the extent to which participation in a counselor education program is accompanied by change in personality characteristics of counseling students. Using several psychological inventories, including the California Psychological Inventory, Kassera and Sease compared groups of students at various levels in a required counseling education program. They found a significant difference between the beginning and advanced groups in a direction considered by the authors to be desirable. When the counseling students were compared to a control group of education students, they were found to be more conscientious, responsible, confident, insightful, and adventurous than these education students according to data from the Socialization and Flexibility scales.

Other research on personality characteristics of therapists has investigated client-therapist matching (Bare, 1967; Lesser, 1961). Most notable in this area was the development of the A-B scale by Whitehorn and Betz (1957,

1969) in which client diagnosis and therapist personality traits were matched.

In another inquiry into the research on personality characteristics undertaken 25 years after Cottle's examination, Parloff, Waskow, and Wolfe (1978) noted a plethora of studies, but concluded that problems of varied methodology and inadequate statistical procedures revealed little reliable information. Parloff et al. did state that there was a general consensus regarding those therapist characteristics "to which all therapists should aspire" including "objectivity, honesty, capacity for relatedness, emotional freedom, security, integrity, humanity, commitment to the patient, intuitiveness, patience, perceptiveness, empathy, creativity, and imaginativeness" (1978, p. 235).

Albert Ellis, the originator of rational-emotive therapy (RET), reflected a new trend in the investigation of therapist personality when he analyzed the influence of personality characteristics on the choice of a theoretical orientation. Ellis concluded that:

The basic personality, as well as the personality disturbances, of psychotherapists are not to be taken lightly. Subtly or quite consciously, they usually (though not always) are important deciding factors in which general school of therapy the practitioner chooses and--perhaps even more

significantly--which specific ways he/she chooses to live with and practice within the framework of this school. (1978, p. 332)

Commenting on the specific personality characteristics of RET therapists, Ellis (1978) described them as more inclined to be confrontational than passive, possessing a high tolerance for diversity, preferring the practical and pragmatic, and being attuned to cognitive and behavioral viewpoints. Therapists who have a low tolerance for diversity and who prefer delving into the unconscious or mystical are not attracted to RET. While admitting that there is room for variance in those personalities who practice RET effectively, Ellis notes that the particular aspects of the orientation which a therapist may choose to emphasize or ignore are influenced by that therapist's personality traits.

The relationship between theoretical orientation and therapist self-concept was explored by Walton (1978) in a study of 134 practicing psychotherapists representing four orientations: eclectic, rational-emotive (RET), psychodynamic, and behavioral. Using a semantic differential instrument, Walton found significant differences among therapists on personality factors of complexity, seriousness, and rationality. Not surprisingly, the RET therapists viewed themselves as higher on

rationality than eclectic therapists viewed themselves. Psychodynamic therapists saw themselves as more serious and complex than the RET therapists saw themselves.

More recently, and most pertinent for the present investigation, is Kolevzon and Green's (1985) study of convergence/divergence from model of 156 graduates of family therapy training programs, used the 16PF to gain personality descriptions for therapists from several family therapy models. The authors reported the least descriptive personality traits for all family therapy model therapists were suspicious and apprehensive. Similarly, there were commonalities on the most descriptive personality traits among the therapists of the different models:

Communication model (Satir):	trusting, self-assured, tender-minded, venturesome
Structural/Strategic model:	trusting, self-assured, assertive
Bowen Systems model:	trusting, self-assured, self-sufficient

Obviously, the personality characteristics of therapists has been the subject of inquiry in the field of psychotherapy research for at least 34 years. Parloff et al. (1978) concluded that the research prior to their 1978 review of the literature was inadequate and unreliable. There was some investigation of personality characteristics

of both clients and therapists which was aimed at discovering good therapeutic matchings. Characteristics to which therapists ought to aspire were noted, but research on the actual personality characteristics which exist among therapists was minimal. One problem was the frequent use of student samples (e.g., psychology, counseling practicum students), rather than experienced therapists, in much of the research. Moreover, samples tended to be small, thus casting doubt as to their generalizability.

The shift toward investigating personality characteristics as they may be related to a therapist's choice of a particular theoretical orientation brought an improvement in the quality of the research. More often the samples were experienced therapists and the sample sizes were larger. Nevertheless, investigation of the personality characteristics of family therapists has been minimal. The Kolevzon and Green study (1985) provided the initial inquiry using this particular sample, but the emphasis here was more on how the therapists converged or diverged from their chosen orientation, and less on what specific personality characteristics actually exist among family therapists. Continued investigation of the personality characteristics of family therapists according to various models is, therefore, appropriate.

Family of Origin Experience.

The experiences of therapists in their families of origin has been the subject of reflection and investigation ever since Freud analyzed himself. Burton (1972), in summarizing common threads in the life stories of twelve male therapists, including Carl Rogers, Erving Polster, and Albert Ellis, noted the occurrence of family backgrounds with considerable disruption and upheaval, idealized fathers, and depreciated mothers. Additionally, Burton found a high incidence of early and sustained physical illness necessitating periods of inaction and introspection among these twelve successful psychotherapists.

Henry (1977) and Henry, Spray, and Sims (1971) reported on a study of 4,000 psychotherapists working in Chicago, New York, and Los Angeles. Results from self-report indicated the therapists had generally good relationships with their families of origin; however, 39% said that their parent's marriages were not good ones. The frequency of traumatic events in the therapist sample paralleled normal expectations with 37% reporting death events in their families and 33% noting some form of illness. Separation was a more significant issue; half of the therapists noted some form of separation in childhood and adolescence. Henry concluded that:

There is very little in these personal backgrounds to suggest experiences leading to emotional distress; nothing to suggest major disassociative experiences, personal hostilities, or severe affective deprivations." (1977, p. 58)

Lackie (1983) studied 1,577 social workers with regard to infantilization/parentification in their families of origin. He reported that over two-thirds of the sample described themselves in terms that identified them as parentified children (i.e., overresponsible, mediator, go-between). Conversely, the social workers rarely described themselves in terms that would identify them as having been infantilized as children. Lackie concluded that the choice of social work as a career might be related to the care-taking role so frequently experienced by social workers in their families of origin.

Racusin, Abramowitz, and Winter (1981) examined the relationship between career choice by psychotherapists and their family of origin experiences. Highly structured interviews were utilized to gather information from 14 clinical psychologists. Data on physical/psychological health in the families of origin revealed that all 14 therapist families had at least one member with physical/behavioral difficulty with the highest incidence occurring among fathers, then mothers, and then the

therapists themselves. Three parents had abused their children and six parents had conditions that are frequently psychogenic in origin. The researchers speculated that these physical/psychological health difficulties might have trained the therapists to sensitivity to interpersonal stress.

The Racusin et al. (1981) study also investigated parental marital status and the role of the therapists in their families of origin ($n=14$ clinical psychologists). Therapists reported seeing themselves as enmeshed in the stressful marriages. The researchers viewed this situation as contributing to the therapist's attraction to an occupation where the stress levels of intimacy can be controlled by the therapist. Nearly half of the therapists said their major role in their families of origin was to provide parenting in the form of nurturance or family functioning and another six therapists saw that role as a secondary one for them. This circumstance, the researchers concluded, may account for the choice of psychotherapy as an occupation in that the client-counselor relationship often builds on the nurturing ability of the therapist.

Burton's (1972) finding of the frequent occurrence of illness in childhood among therapists and the Racusin et al. (1981) investigation of health problems in the families of origin of therapists further delineates the stress-illness

connection. Cooley and Keesey (1981) examined that relationship in a sample of 136 undergraduate psychology students using, among other instruments, the Myers-Briggs Type Indicator. Results indicated that Introverted types, Thinking types, and Sensing types showed larger correlations between life stress and illness than did the Extraverted types, Feeling types, and Intuitive types. This finding, along with earlier evidence that psychotherapists most commonly are Intuitive types, would suggest that therapists have learned to deal with life stress in ways that are fairly health-promoting.

The research undertaken to study family of origin experiences of therapists and their influence on choice of occupation or orientation has used small samples, with the notable exception of the Henry et al. (1971) study of 4,000 psychotherapists and the Lackie (1983) study of 1,577 social workers. However, at least in this area of inquiry, most of the research has used practicing therapists as opposed to counseling education or psychology students. In addition, there must be some caution as to the reliability of results since much of the research provided only qualitative data using structured interviews. Nevertheless, none of the research here has addressed the family of origin experiences of family therapists (directly, that is; the social worker study by Lackie probably included some family therapists).

This is especially interesting since family therapists have chosen a theoretical orientation that deliberately focuses on family and on family of origin as opposed to the more common individual orientation in most psychotherapy.

The research on family of origin factors among therapists that has been thus far undertaken also has not made sufficient inquiry into the specific variable of loss/transition events. Again, the problem of small samples presents itself. Moreover, the research has focussed on other variables, such as parental marital stress or infantilization/parentification, rather than on the specific variables of loss/transition. Therefore, further investigation in loss/transition factors in the families of origin of family therapists is appropriate.

Summary

The family therapy movement, while united by the systems perspective regarding human relationships, includes a variety of orientations in diagnosis, foci of treatment, view of systems properties, and technique. Furthermore, the differences among these orientations are especially evident in the role of training of therapists.

The Systems (Bowen) and Process (Satir) models assert the importance of the therapist's own self-knowledge. It is thought that awareness of one's own behavioral preferences,

values, and personal issues might assist the therapist in preventing unwarranted intrusion of these variables into the therapeutic process. Furthermore, investigation of self is undertaken according to the precepts of a particular model as a means of training therapists in the characteristics of that model. Thus, Systems and Process model therapists actively investigate family of origin experiences, re-connection opportunities, and differentiating events. Systems model therapists rely on this self-knowledge to maintain objectivity and direction in the therapy. Process model therapists use this self-knowledge to assist in building productive client-therapist relationships.

The Structural (Minuchin) model is not concerned with therapist self-knowledge. Since this model does not rely so much on the person of the therapist in relationship to the clients, but relies instead on the intentional maneuvering of transactions and structure, the lack of emphasis on the therapist's self-knowledge is understandable. The training emphasis, instead, is on the cognitive and behavioral dimensions of the therapist's activity. This is not to say that the client-therapist relationship is unimportant in the Structural model. Rather, preoccupation with the person of the therapist is regarded as detrimental to the implementation of these specific models.

The literature regarding the typological preferences, personality characteristics, and family of origin experiences of therapists reveals some commonality among all therapists and some variation among therapists representing different orientations. Most notable is the common occurrence of Intuitive types among all therapists. Additionally, it appears, in at least one study of family therapists, that the characteristics of being self-assured and trusting are shared personality traits.

However, differences abound. Therapists from behavioral, psychoanalytic, and experiential orientations reveal typological differences in their preferences as Thinking types and Feeling types, or Judging types and Perceiving types. It appears that an orientation toward the quality of the client-therapist relationship is characteristic of Introverted-Feeling types where an orientation toward behavioral patterns is characteristic of Introverted-Thinking types. Therapists representing Satir's Process model were characterized as tender-minded and venturesome; those from Bowen's Systems model were characterized as self-sufficient; and those therapists representing the Structural/Strategic model were found to be assertive.

Research on family of origin experiences of therapists does not provide data that can be sufficiently generalized

to reveal characteristic traits or events. Some of the research, notably that of Henry (1977) and Henry, Spray, and Sims (1971) indicates no differences in family of origin experiences between therapists and other populations, but this bypasses the issue of differences among therapeutic orientations. Therefore, differences and commonalities among therapists, especially among family therapists, regarding family of origin experiences, remains a largely uninvestigated field.

The theoretical orientation chosen by a psychotherapist provides a framework for understanding and managing client issues, is a way of conceptualizing the therapist's own role in the therapeutic process, and acts as a bridge between the therapist's personal and clinical experiences. This choice is crucial, not only for the novice therapist, but for the experienced one as well. An appropriate matching of orientation to therapist is most desirable for good psychotherapeutic practice. Specific knowledge of the characteristics most often associated with a particular orientation within the family therapy field will assist in the training of student therapists. Training programs can be designed so that those students whose characteristics are most similar to those of therapists from a particular approach to family therapy might be referred to that approach as an area worthy of their investigation.

Additionally, knowledge about the characteristics most often associated with a specific approach to family therapy can aid investigation of the manner in which a therapists best utilizes his/her own personhood in therapeutic practice. Therefore, it is important to investigate those variables which contribute to the choice of a theoretical orientation by a psychotherapist. Typological preferences, personality characteristics, and family of origin factors are three such variables. Moreover, since family therapists are under-represented in the minimal research done on these variables previously, it is appropriate to use a sample of therapists from various family therapy models in any investigation of theoretical orientation and psychosocial factors.

Chapter 3: Methods and Procedures

This chapter describes the design and methodology for implementing the present research study. It includes a description of the sample population, a review of instrumentation, a discussion of the procedures to be followed, including statistical methods, and a statement of research hypotheses.

Description of Population

The sample for the present study was drawn from therapists representing three different theoretical orientations within the family systems therapy field. Since the intent of the study was to investigate the psychosocial characteristics of therapists according to certain known theoretical orientations, it was important to have selected participants who most closely reflected a particular orientation in their practice in contrast to therapists who, while trained in a particular orientation, may not in actual practice truly reflect that model. Therefore, major advocates of each family systems orientation were asked to provide the names of 60 persons who were trained in their particular models and whose practice reflects adherence to the principles of that model.

Additionally, the model advocates were asked to provide a cover letter encouraging participation in the study which was to accompany the instrument package. It was believed that such cooperation on the part of the model advocates would have assisted in insuring a high rate of return. The following advocates were asked to participate:

Dr. Virginia Satir	-	Process Model
Dr. Salvador Minuchin	-	Structural Model
Dr. Michael Kerr	-	Systems Model

Dr. Satir provided a list of 64 names of persons well-trained in the Process model and a cover letter to accompany the instrument packages. Dr. Kerr, of The Family Center at Georgetown University, declined to provide a cover letter, but did supply a list of 60 names of trainees viewed as having achieved expertise in family systems theory according to the Bowen model. Dr. Minuchin referred the researcher to the Director, Family Therapy Training Center at the Philadelphia Child Guidance Clinic, Dr. Marion Lindblad-Goldberg. Dr. Lindblad-Goldberg selected 60 participants well-trained in the Structural model and provided administrative support in contacting those participants.

Procedure

The instrument package was mailed to 184 family systems therapists representing the three different theoretical orientations within the field. Each package contained the following material:

1. Cover letter from the model founder or major advocate
2. Cover letter and instructions from the researcher
3. Consent Form
4. Therapist Information Form
5. Adjective Check List
6. Myers-Briggs Type Indicator
7. Nodal Events Survey

Instruments were coded as a precaution for confidentiality. The instrument package could be completed in an hour to an hour-and-a-half and required no special equipment or setting. Those participants who had already taken the MBTI and recalled their typology and scores were asked to provide that information to the researcher in lieu of completing the MBTI. However, if such information was not available, they were asked to complete the instrument again.

Instrumentation

Four instruments are used in the present study. The Myers-Briggs Type Indicator and the Adjective Check List are well-known instruments with demonstrated validity and reliability. The Nodal Events Survey and Therapist Information Form were developed specifically for this project and, therefore, have no demonstrated statistical bases.

Myers-Briggs Type Indicator (MBTI).

The Myers-Briggs Type Indicator is a 166-item forced-choice instrument developed by Katherine Myers and Isabel Briggs Myers (1962) to measure Jung's theory of psychological type. The MBTI provides four scores on the bi-polar scales: Extraversion-Introversion (E-I), Intuition-Sensation (N-S), Thinking-Feeling (T-F), and Judging-Perception (J-P). The instrument is self-administering, can be completed in 30-40 minutes, and is appropriate for use with grades 9-12 and adults. Respondents choose between two statements on each item that best describe themselves. Scoring provides point scores for each scale which are converted into four preference scores, one for each of the scales. The MBTI manual suggests the use of continuous scores when using the MBTI for statistical

purposes. These are obtained for Introversion, Intuition, Feeling, and Perception scores by adding 100 to the preference score already established; for Extraversion, Sensation, Thinking, and Judging scores the continuous score is 100 minus the preference score.

Since the MBTI is based on Jung's theory of psychological type, validity is ascertained by correlation with other measures of psychological type. One such instrument, the Gray-Wheelwright Psychological Type Questionnaire, does not include the Judging-Perception scale. However, correlations between the other scales on the two instruments are very high: E-I scale=.79, S-N scale=.58, T-F scale=.60 (Myers, 1962). Correlation of the MBTI with various scales from the Minnesota Multiphasic Personality Inventory yielded correlations of -.23 to .63 for the E-I scale; -.07 to .33 for the S-N scale; -.17 to .22 for the T-F scale; and -.30 to .23 for the J-P scale (Myers & McCaulley, 1986).

Reliability correlations, as reported by the MBTI manual (Myers, 1962) and the MBTI Researcher's Guide (McCaulley, 1977), provide coefficients from various samples. Split-half reliability using the Spearman-Brown formula with samples of high school students ($n=807$) obtained correlations between halves of which the only coefficients below .75 were for underachieving 8th graders

and non-prep 12th graders. Test-retest reliabilities for MBTI continuous scores for 7th grade students ($n=77$), college students ($n=182$), medical students ($n=91$), and male and female undergraduates ($n=433$) include:

E-I scale range = .73-.83

S-N scale range = .69-.83

T-F scale range = .60-.82

J-P scale range = .64-.82

Coan (1978), commenting in The Eighth Mental Measurements Yearbook, notes that "the group differences and correlations are broadly supportive of the construct validity of the scales" (p. 975). Mendelsohn (1965), reviewing the MBTI in The Sixth Mental Measurements Yearbook, found the MBTI scores "relate meaningfully to a large number of variables, including personality, ability, interest, value, aptitude and performance measures, academic choice, and behavior ratings" (p. 322). DeVito (1985) reviewed the MBTI in The Ninth Mental Measurements Yearbook and noted that the MBTI is "probably the most widely used instrument for non-psychiatric populations in areas of clinical, counseling, and personality testing" (p. 1030). The validity and reliability of the Myers-Briggs Type Indicator is considered sufficient for the purposes of this research project.

Adjective Check List.

The Adjective Check List (ACL) is a self-administered instrument containing 300 adjectives commonly used to describe personality attributes (Gough & Heilbrun, 1980). The instrument may be completed in 10-15 minutes. The ACL provides 37 scales including 15 scales derived from Murray's need-press theory, five topical scales, four modus operandi scales, five transactional analysis scales, and four origence-intellectence scales. Raw scores on the ACL are converted to standard scores using tables provided in the manual (Gough & Heilburn, 1980). The present study will utilize 10 of the 37 scales, excluding the modus operandi, transactional analysis, and origence-intellectence scales since their application to the present study is not appropriate. The scales used in the present study include:

1. Achievement
2. Dominance
3. Endurance
4. Order
5. Nurturance
6. Autonomy
7. Change
8. Self-Confidence
9. Self-Control
10. Personal Adjustment

The Adjective Check List was normed on a sample of 5,238 males and 4,141 females who were highly diversified in age, education, occupation or occupational preference, intelligence, and social status.

Reliability information presented in the manual (Gough & Heilburn, 1980) includes alpha coefficients ranging from .56 for Change and Succorance to .95 for Favorable Adjectives Checked, with a median coefficient of .75. For females the range was from .53 for Counseling Readiness to .94 for Favorable Adjectives Checked, with a median coefficient of .75. Test-retest correlations reported on a male sample of 199 subjects resulted in a range of coefficients from .34 to .77 with a median coefficient of .65. A female sample of college students revealed coefficients of .45 to .86 with a median coefficient of .71.

Zarske (1985), commenting in The Ninth Mental Measurements Yearbook, notes that "the primary strength of the ACL has been, and remains, that of a research instrument tied to theoretical developments in the area of personality" (p. 52). Teeter (1985) summarized her review by stating that "the ACL appears to be a well developed and relatively reliable instrument" (p. 52). The validity and reliability of the Adjective Check List is acceptable for use as a measure of personality for the present study.

Nodal Events Survey.

The Nodal Events Survey is a modification (by the researcher) (Appendix A) of the Family Change Inventory used in the Family Research Project (Winter, 1987) which took

place in Virginia 1980-1981. The survey is self-administering and takes approximately 10-20 minutes to complete. Respondents are asked to answer yes or no to questions about the occurrence of certain loss/transition events in their families of origin. Additionally, information regarding the approximate age of the respondent when the event took place is requested. Areas of inquiry include:

- Deaths in the family
- Separations in the family
- Serious illness in the family
- Family member disabled or handicapped
- Family member placed in an institution
- Times and location of moves up to 18 years of age
- Occurrence of alcohol abuse in the family
- Occurrence of drug abuse in the family
- Occurrence of physical/emotional abuse in the family
- Occurrence of financial difficulty in the family
- Occurrence of employment problems for parents

Therapist Information Form.

The Therapist Information Form (Appendix B) was designed by the researcher to elicit demographic information about the respondent including: age, sex, race, marital status, formal education, professional experience, current client caseload, family of origin parenting information, sibling position, immigration status, and ethnic influences. The form takes approximately 5-10 minutes to complete.

Statistical Procedure and Hypotheses

Parametric statistical tests must satisfy several criteria including the assumption of normality, the assumption of homogeneity of variance, and dependent variables (scores) that can be analyzed in continuous form with equal intervals of quantity measurement (Balian, 1982). These criteria are satisfied for the Myers-Briggs Type Indicator and the Adjective Check List. Analysis of variance (ANOVA) is a statistical technique that is used to determine whether the groups differ significantly among themselves (Borg & Gall, 1983) and thus is the appropriate statistical procedure to use in the present study. An alpha level of .05 will apply. Descriptive statistics will be reported on data from the Nodal Events Survey.

The following hypotheses are made:

- H_{(R) 1} There will be statistically significant differences in psychological type preference on the Extraversion-Introversion scale among therapists from the Process, Structural, and Systems models.
- H_{(R) 2} There will be statistically significant differences in psychological type preference on the Sensation-Intuition scales among therapists from the Process, Structural, and Systems models.
- H_{(R) 3} There will be statistically significant differences in psychological type preference on the Thinking-Feeling scale among therapists from the Process, Structural, and Systems models.

- $H_{(R)4}$ There will be statistically significant differences in psychological type preference on the Judging-Perception scale among therapists from the Process, Structural, and Systems models.
- $H_{(R)5}$ There will be statistically significant differences in personality attributes according to the Achievement scale among therapists from the Process, Structural, and Systems models.
- $H_{(R)6}$ There will be statistically significant differences in personality attributes according to the Dominance scale among therapists from the Process, Structural, and Systems models.
- $H_{(R)7}$ There will be statistically significant differences in personality attributes according to the Endurance scale among therapists from the Process, Structural, and Systems models.
- $H_{(R)8}$ There will be statistically significant differences in personality attributes according to the Order scale among therapists from the Process, Structural, and Systems models.
- $H_{(R)9}$ There will be statistically significant differences in personality attributes according to the Nurturance scale among therapists from the Process, Structural, and Systems models.
- $H_{(R)10}$ There will be statistically significant differences in personality attributes according to the Autonomy scale among therapists from the Process, Structural, and Systems models.
- $H_{(R)11}$ There will be statistically significant differences in personality attributes according to the Change scale among therapists from the Process, Structural, and Systems models.
- $H_{(R)12}$ There will be statistically significant differences in personality attributes according to the Self-Confidence scale among therapists from the Process, Structural, and Systems models.
- $H_{(R)13}$ There will be statistically significant differences in personality attributes according to the Self-Control scale among therapists from the Process, Structural, and Systems models.

- H_(R)14 There will be statistically significant differences in personality attributes according to the Personal Adjustment scale among therapists from the Process, Structural, and Systems models.
- H_(R)15 There will be differences in total death events indicated on the Deaths in Family scale among therapists from the Process, Structural, and Systems models.
- H_(R)16 There will be differences in the occurrence of death events associated with specific family members according to the Deaths in Family scale among therapists from the Process, Structural, and Systems models.
- H_(R)17 There will be differences in therapist's ages at the occurrence of death events associated with specific family members according to the Deaths in Family scale among therapists from the Process, Structural, and Systems models.
- H_(R)18 There will be differences in the total occurrence of suicide events indicated on the Deaths in Family scale among therapists from the Process, Structural, and Systems models.
- H_(R)19 There will be differences in the total occurrence of murder events indicated on the Deaths in Family scale among therapists from the Process, Structural, and Systems models.
- H_(R)20 There will be differences of the family members who died as the result of suicide on the Deaths in Family scale among therapists from the Process, Structural, and Systems models.
- H_(R)21 There will be differences in the therapist's ages at the death of family members who died as the result of suicide on the Deaths in Family scale among therapists from the Process, Structural, and Systems models.
- H_(R)22 There will be differences in the family members who died as the result of murder on the Deaths in Family scale among therapists from the Process, Structural, and Systems models.

- H(R) 23 There will be differences in the therapist's ages at the death of family members who died as the result of murder on the Deaths in Family scale among therapists from the Process, Structural, and Systems models.
- H(R) 24 There will be differences in the total occurrence of family separations on the Separations in Family scale among therapists from the Process, Structural, and Systems models.
- H(R) 25 There will be differences in the occurrence of whole families who split up on the Separations in Family scale among therapists from the Process, Structural, and Systems models.
- H(R) 26 There will be differences in the therapist's ages when whole families who split up on the Separations in Family scale among therapists from the Process, Structural, and Systems models.
- H(R) 27 There will be differences in the occurrence of parental separation as indicated on the Separations in Family scale among therapists from the Process, Structural, and Systems models.
- H(R) 28 There will be differences in the therapist's ages when parents separated as indicated on the Separations in Family scale among therapists from the Process, Structural, and Systems models.
- H(R) 29 There will be differences in the occurrence of parental desertion as indicated on the Separations in Family scale among therapists from the Process, Structural, and Systems models.
- H(R) 30 There will be differences in the therapist's ages when parental desertion occurred as indicated on the Separations in Family scale among therapists from the Process, Structural, and Systems models.
- H(R) 31 There will be differences in the total occurrence of serious illness associated with specific family members according to the Serious Illness in Family scale among therapists from the Process, Structural, and Systems models.

- H(R)32 There will be differences in the occurrence of serious illness associated with specific family members according to the Serious Illness in Family scale among therapists from the Process, Structural, and Systems models.
- H(R)33 There will be differences in the therapist's ages when a serious illness associated with specific family members occurred according to the Serious Illness in Family scale among therapists from the Process, Structural, and Systems models.
- H(R)34 There will be differences in the total occurrence of disability/handicapped conditions on the Family Member Disabled or Handicapped scale among therapists from the Process, Structural, and Systems models.
- H(R)35 There will be differences in the occurrence of disability/handicapped conditions associated with specific family members according to the Family Member Disabled or Handicapped scale among therapists from the Process, Structural, and Systems models.
- H(R)36 There will be differences in the therapist's ages when a disability/handicapped condition associated with specific family members occurred according to the Family Member Disabled or Handicapped scale among therapists from the Process, Structural, and Systems model.
- H(R)37 There will be differences in the total occurrence of institutionalization on the Family Member Placed in Institution scale among therapists from the Process, Structural, and Systems models.
- H(R)38 There will be differences in the occurrence of institutionalization on the Family Member Placed in Institution scale among therapists from the Process, Structural, and Systems models.
- H(R)39 There will be differences in the therapist's ages when an institutionalization associated with specific family members occurred according to the Family Member Placed in Institution scale among therapists from the Process, Structural, and Systems models.

- H_(R) 40 There will be differences in the total occurrence of moving events on the Moving Events scale among therapists from the Process, Structural, and Systems models.
- H_(R) 41 There will be differences in the occurrence of moves within the same general area on the Moving Events scale among therapists from the Process, Structural, and Systems models.
- H_(R) 42 There will be differences in the occurrence of moves to another state on the Moving Events scale among therapists from the Process, Structural, and Systems models.
- H_(R) 43 There will be differences in the occurrence of moves to another geographic region on the Moving Events scale among therapists from the Process, Structural, and Systems models.
- H_(R) 44 There will be differences in the occurrence of moves to another country on the Moving Events scale among therapists from the Process, Structural, and Systems models.
- H_(R) 45 There will be differences in the total occurrence of alcohol abuse on the Alcohol Abuse scale among therapists from the Process, Structural, and Systems models.
- H_(R) 46 There will be differences in the occurrence of alcohol abuse associated with specific family members on the Alcohol Abuse scale among therapists from the Process, Structural, and Systems models.
- H_(R) 47 There will be differences in the total occurrence of drug abuse on the Drug Abuse scale among therapists from the Process, Structural, and Systems models.
- H_(R) 48 There will be differences in the occurrence of drug abuse associated with specific family members on the Drug Abuse scale among therapists from the Process, Structural, and Systems models.

- H_(R) 49 There will be differences in the total occurrence of physical/emotional abuse on the Physical/Emotional Abuse scale among therapists from the Process, Structural, and Systems models.
- H_(R) 50 There will be differences in the occurrence of physical/emotional abuse between parents on the Physical/Emotional Abuse scale among therapists from the Process, Structural, and Systems models.
- H_(R) 51 There will be differences in the occurrence of physical/emotional abuse between parent and child on the Physical/Emotional Abuse scale among therapists from the Process, Structural, and Systems models.
- H_(R) 52 There will be differences in the occurrence of physical/emotional abuse involving the therapist in his/her family of origin on the Physical/Emotional Abuse scale among therapists from the Process, Structural, and Systems models.
- H_(R) 53 There will be differences in the total occurrence of financial deprivation in their family of origin among therapists from the Process, Structural, and Systems models.
- H_(R) 54 There will be differences in the total occurrence of parental difficulty in obtaining employment among therapists from the Process, Structural, and Systems models.
- H_(R) 55 There will be differences in the occurrence of parental employment which necessitated periods away from the family among therapists from the Process, Structural, and Systems models.
- H_(R) 56 There will be differences in the length of time of parental employment which necessitated periods away from the family among therapists from the Process, Structural, and Systems models.
- H_(R) 57 There will be differences in which parenting adult was involved of therapists whose parent's employment necessitated periods away from the family among therapists from the Process, Structural, and Systems models.

Summary of Methodology

The purpose of the present study was to explore and describe certain psychosocial characteristics of therapists according to several theoretical orientations with the field of family systems therapy. These characteristics include psychological type, personality factors, and the occurrence of loss/transition events in the family of origin. Three models of family therapy were investigated: Virginia Satir's Process model, Salvador Minuchin's Structural model, and Murray Bowen's Systems model.

Advocates from each of the three models provided the names and addresses of persons who were trained in and exemplified the principles of that particular model in their therapeutic practice ($n=184$). Each participant received an instrument package which included three test instruments, one information form, a letter of instruction from the researcher, and a consent form (Appendix C). Those representing the Process model also received a cover letter from Dr. Satir.

The instrument package included: the Adjective Check List, the Myers-Briggs Type Indicator, the Nodal Events Survey, and the Therapist Information Form. All instruments were coded by number so as to guarantee confidentiality.

Chapter 4: Results

This chapter includes the results of data collection and statistical analyses pertaining to each hypothesis. Information is reported in three sections. First, demographic data from the Client Information Form provides a description of the subjects (Ss) who comprise the sample from the Process, Structural, and Systems models. Second, the hypotheses regarding results from the Myers-Briggs Type Indicator (MBTI) and the Adjective Check List (ACL) are evaluated to determine the existence of statistical significance. Third, the results from the Nodal Events Survey are evaluated and reported on the basis of descriptive statistics.

A total of 184 instrument packets were mailed to therapists representing three different theoretical orientations within the family systems therapy field. A return rate of 41.9% ($n=77$) was achieved. There was a substantial difference in the return rates from therapists in each model. Of the 64 therapists from the Process model who were sent instrument packets, 68.8% ($n=44$) returned the completed instruments. Of the 60 therapists from the Structural model who were sent packets, 26.7% ($n=16$)

returned the completed instruments. Of the 60 therapists from the Systems model who were sent packets, 28.3% ($n=17$) returned the completed instruments. Therefore, the results of this study are based on 44 Ss from the Process model, 16 Ss from the Structural model, and 17 Ss from the Systems model.

Description of the Sample

Information from the Client Information Form provides a description of Ss according to the theoretical model which they represent. A detailed summary of this information is provided in Tables 1 through 9. Age information revealed a mean age of 51.4 years for Ss from the Process model, 40.9 years for Ss from the Structural model, and 45.9 years for Ss from the Systems model. Females ($n=26$) outnumbered males ($n=18$) in the Process model, females ($n=8$) and males ($n=8$) were equally represented in the Structural model, and males ($n=10$) outnumbered females ($n=7$) in the Systems model. Whites far outnumbered blacks in the total sample with one black therapist reported in the Structural model. Most Ss in each group of the total sample were married ($n=54$) (see Table 4.1).

Results pertaining to the highest educational degree earned by Ss indicated 38.6% ($n=17$) of Ss from the Process model, 56.3% ($n=9$) of Ss from the Structural model, and

11.8% ($n=2$) of Ss from the Systems model had earned doctorates (medicine/non-medicine). Masters of Social Work degrees were also well-represented in the sample: 20.5% ($n=9$) of the Process model, 18.8% ($n=3$) of the Structural model, and 58.8% ($n=10$) of the Systems model (see Table 4.2).

Information was gathered on the previous and current professional experience of Ss from each model (see Tables 4.3 and 4.4). Previous experience in a community mental health setting was most frequently reported by Ss from the Process ($n=13$) and Structural model ($n=10$). Community and mental health ($n=8$) and hospital/health settings ($n=8$) were the most frequently indicated previous experience for Ss from the Systems model. Current experience in private practice was the setting most frequently reported by all Ss in the sample: Process model ($n=28$), Structural model ($n=9$), and Systems model ($n=10$).

Data regarding the current client caseload of Ss from each model was also acquired (see Table 4.5). Ss were asked to indicate the percentage of time they estimated they spent with four particular groupings of clients: individual, couples, families, and groups. It should be noted that a record of estimated time with individuals or groups is not necessarily an indication of non-family systems work. Rather, it is an indication only of the particular client

group with which the therapist might be working. Results were reported as the mean percent of the total caseload of Ss from each model. Ss from the Process and Systems models reported most of their counseling time was spent with individuals (Process model: 32.7%; Systems model: 63.7%). Ss from the Structural model spent most of their counseling time with families (77.3%). It is notable also that Ss from the Structural and Systems models spent very little time with groups (Structural model: .8%; Systems model: 2.0%), and Ss from the Structural model spent relatively little time with couples (5.2%).

Ss were asked to report the adults who were most responsible for parenting duties during their childhood (see Table 4.6). One hundred percent of the Ss from the Structural and Systems models, and 93.2% ($n=41$) of the Ss from the Process model indicated their mothers as an adult most responsible for parenting. The presence of the father in parenting was noted less frequently: 63.6% ($n=28$) from the Process model, 62.5% ($n=10$) from the Structural model, and 70.6% ($n=12$) from the Systems model.

Data were collected pertaining to sibling status of the Ss from each model (see Table 4.7). Information about the size of sibling constellations indicated that most of the Ss came from families with 3-5 siblings: 50.0% ($n=22$) of Ss from the Process model, 56.25% ($n=9$) from the Structural

model, and 70.6% ($n=12$) of Ss from the Systems model. There were three only-child constellations reported by Ss from the Process model, and no only-child constellations reported by Ss in either the Structural or Systems models.

Information about the sibling position of Ss was gathered as well (see Table 4.8). In the Process model, most Ss were youngest siblings (36.36%, $n=16$), with the oldest sibling position occupied slightly less frequently (29.55%, $n=13$). In the Structural model, most Ss were oldest siblings (56.25%, $n=9$), with middle (18.75%, $n=3$) and youngest (18.75%, $n=3$) positions occupied equally. In the Systems model, most Ss were oldest siblings (52.9%, $n=9$), with the youngest sibling position occupied next most frequently (29.4%, $n=5$).

Results concerning the generation which Ss represent since their families of origin immigrated to the United States or Canada indicated that the families of most Ss had been in North America for three or more generations (50.7%, $n=39$). Most of the families of Ss from the Process (36.4%, $n=16$) and Systems (64.7%, $n=11$) models had been in North America for four or more generations, while most families of Ss from the Structural model had been in North America three or more generations (37.50%, $n=6$). First generation immigration status was reported to be 13.6% ($n=6$) for

Process model Ss, 12.50% ($n=2$) for Structural model Ss, and 11.8% ($n=2$) for Systems model Ss (see Table 4.9).

Inquiry was also made about the primary ethnic/regional influences experienced by Ss from each model. The most frequently named influences among Ss from the Process model were German, British, and Irish; the most frequently named influences among Ss from the Structural model were British, Irish, Jewish, and urban; the most frequently named influences among Ss from the Systems model were British, German, and Irish (see Table 4.10).

Table 4.1

Demographic Information of Subjects by Model

	Process Model (n = 44)			Structural Model (n = 16)			Systems Model (n = 17)		
Age	X	= 51.4 yrs		X	= 40.9 yrs		X	= 45.9 yrs	
	Range:	35-81 yrs		Range:	27-69 yrs		Range:	36-69 yrs	
	Median:	51 yrs		Median:	39 yrs		Median:	45 yrs	
Gender	female	26		female	8		female	7	
	male	18		male	8		male	10	
Race	black	0		black	1		black	0	
	white	43		white	15		white	16	
	unknown	1		unknown	0		unknown	1	
Marital	single	4		single	3		single	0	
Status	widowed	3		widowed	0		widowed	0	
	married	28		married	11		married	15	
	sep/div	9		sep/div	2		sep/div	2	

Table 4.2

Highest Degree Earned of Subjects by Model

Model	n	M.D.	Doctor	Doctoral Candidate	Ed.S.	Masters	MSW	Bachelors	Associate	Other
Process	44	5	12	3	1	10	9	1	2	1
Structural	16	2	7	0	0	3	3	0	1	0
Systems	17	0	2	1	0	4	10	0	0	0
<hr/>										
Doctoral Degree:	<u>Process:</u>	counselor education (2), psychology (8), social work (1), theology (1)								
	<u>Structural:</u>	counseling/psychology (7)								
	<u>Systems:</u>	education (1), psychology (1)								
Doctoral Candidate:	<u>Process:</u>	family life education (1), psychology (2)								
	<u>Structural:</u>	---								
	<u>Systems:</u>	psychology (1)								
Masters:	<u>Process:</u>	communication/human behavior (1), nursing (2), psychology/counseling (3), sociology (1), theology (2), unknown (1)								
	<u>Structural:</u>	adult education (1), counseling (1), psychiatric nursing (1)								
	<u>Systems:</u>	nursing (1), theology (1), unknown (2)								

Table 4.3

Professional Experience of Subjects by Model: Previous Setting

Previous Setting	Process Model (n = 44)			Structural Model (n = 16)			Systems Model (n = 17)		
	n	X yrs	Range	n	X yrs	Range	n	X yrs	Range
Community Mental Health	13	4.8	1-8 yrs	10	3.9	1-8 yrs	8	4.3	1-10 yrs
Corrections	4	5.0	2-10 yrs	-	-	-	2	2.0	1-3 yrs
Counselor Education	3	2.7	1-4 yrs	1	4.0	-	-	-	-
Hospital/Health	7	11.0	2-24 yrs	2	6.5	5-8 yrs	9	7.8	2-20 yrs
Family Agency (public)	4	3.0	1-7 yrs	1	8.0	-	4	5.8	1-11 yrs
Pastoral Counseling	5	11.0	1-24 yrs	-	-	-	-	-	-
Private Practice	9	11.1	5-22 yrs	1	9.0	-	5	7.0	2-13 yrs
Psychiatric Nursing	1	1.0	-	1	2.0	-	1	25.0	-
School/Guidance	3	2.3	1-3 yrs	-	-	-	2	4.0	1-7 yrs
Social Welfare	3	3.7	2-7 yrs	-	-	-	2	2.0	1-3 yrs
<u>Other Settings</u>									
College Counseling	4	-	-	-	-	-	1	2.5	-
HMO	1	-	-	-	-	-	1	24.0	-
Public Health Nursing	1	4.0	-	-	-	-	-	-	-
Residential Counseling	1	2.0	-	-	-	-	-	-	-
Teaching	4	13.0	4-30 yrs	1	7.0	-	1	7.0	-

Table 4.4

Professional Experience of Subjects by Model: Current Setting

Current Setting	Process Model (n = 44)			Structural Model (n = 16)			Systems Model (n = 17)		
	n	X yrs	Range	n	X yrs	Range	n	X yrs	Range
Community Mental Health	4	15.5	4-40 yrs	6	5.6	3.5-14 yrs	4	6.9	2-13 yrs
Corrections	1	4.0	-	1	1.5	-	1	4.0	-
Counselor Education	7	10.0	4-16 yrs	-	-	-	-	-	-
Hospital/Health	3	11.3	7-15 yrs	6	2.3	1.5-10 yrs	1	5.0	-
Family Agency (public)	1	11.0	-	3	2.0	2-10 yrs	3	10.3	3-17 yrs
Pastoral Counseling	1	33.0	-	-	-	-	1	9.0	-
Private Practice	28	13.4	2-48 yrs	9	6.2	1-15 yrs	10	6.9	5-12 yrs
Psychiatric Nursing	-	-	-	1	1.5	-	-	-	-
School/Guidance	3	8.0	1-15 yrs	-	-	-	-	-	-
Social Welfare	3	9.3	4-14 yrs	-	-	-	1	7.0	-
<u>Other Settings</u>									
College Counseling	1	10.0	-	-	-	-	-	-	-
Residential Counseling	1	15.0	-	-	-	-	-	-	-
Substance Abuse Counseling	2	7.0	5-9 yrs	-	-	-	-	-	-
Teaching	7	11.0	7-17 yrs	-	-	-	2	8.8	8-9.5 yrs

Table 4.5

Current Client Caseload of Subjects by Model

Client	Process Model ($n = 44$)			Structural Model ($n = 16$)			Systems Model ($n = 17$)		
	n	caseload	Range	n	caseload	Range	n	caseload	Range
Individual	37	32.7%	5-100%	16	16.7%	0-60%	15	63.7%	25-100%
Couples	37	23.9%	0-55%	16	5.2%	0-10%	15	22.3%	0-50%
Families	37	24.9%	0-90%	16	77.3%	0-100%	15	12.0%	0-50%
Groups	37	18.5%	0-70%	16	8%	0-10%	15	2.0%	0-10%

Table 4.6

Adults Most Responsible for Parenting during Childhood of Subjects by Model

Adult	Process Model (n = 44)		Structural Model (n = 16)		Systems Model (n = 17)	
	n	Percent of total Ss	n	Percent of total Ss	n	Percent of total Ss
Mother	41	93.2%	16	100.0%	17	100.0%
Father	28	63.6%	10	62.5%	12	70.6%
Grandmother	5	11.4%	2	12.5%	3	17.7%
Grandfather	2	4.6%	-	-	-	-
Aunt	2	4.6%	-	-	1	5.9%
Uncle	1	2.3%	-	-	1	5.9%
Non-related guardian	3	6.8%	-	-	-	-

Table 4.7

Size of Sibling Constellation in Family of Origin of Subjects by Model

Constellation	Process Model ($n = 44$)		Structural Model ($n = 16$)		Systems Model ($n = 17$)	
	n	Percent of total Ss	n	Percent of total Ss	n	Percent of total Ss
2 siblings	11	25.0%	5	31.25%	5	29.4%
3-5 siblings	22	50.0%	9	56.25%	12	70.6%
6+ siblings	4	9.1%	2	12.50%	-	-
Subject as only child	3	6.8%	-	-	-	-
Unknown	4	9.1%	-	-	-	-

Table 4.8

Sibling Position in Family of Origin of Subjects by Model

Sibling Position	Process Model \bar{n}	Structural Model \bar{n}	Systems Model \bar{n}
Oldest brother of brother(s)	3	1	1
Youngest brother of brother(s)	3	0	1
Oldest brother of sister(s)	2	2	1
Youngest brother of sister(s)	2	0	2
Male only child	1	0	0
Oldest sister of sister(s)	4	0	2
Youngest sister of sister(s)	3	1	0
Oldest sister of brother(s)	2	2	2
Youngest sister of brother(s)	3	0	0
Female only child	2	0	0
Oldest brother of brother(s) and sister(s)	0	2	0
Youngest brother of brother(s) and sister(s)	4	1	1
Oldest sister of brother(s) and sister(s)	2	2	3
Youngest sister of brother(s) and sister(s)	1	1	1
Middle child (sister)	6	2	2
Middle child (brother)	2	1	1
Unknown	4	1	-
	$\bar{n} = 44$	$\bar{n} = 16$	$\bar{n} = 17$

Table 4.9

Generation of Subjects since Family of Origin Immigrated to the United States or Canada by Model

Generation	Process Model ($n = 44$)		Structural Model ($n = 16$)		Systems Model ($n = 17$)	
	n	Percent of total Ss	n	Percent of total Ss	n	Percent of total Ss
Don't know/unknown	4	9.0%	1	6.25%	.	.
First	6	13.6%	2	12.50%	2	11.8%
Second	9	20.5%	4	25.00%	1	5.9%
Third	9	20.5%	6	37.50%	3	17.6%
Fourth +	16	36.4%	3	18.75%	11	64.7%

Table 4.10

Primary Ethnic/Regional Influences in Family of Origin of Subjects by Model

	Process Model (n = 44)	Structural Model (n = 16)	Systems Model (n = 17)
Influence	n	n	n
American Indian	1	-	-
Black	-	1	-
Bohemian	1	-	-
British	6	3	5
Catholic	-	-	1
Czechoslovakian	-	-	1
Dutch	1	-	1
Eastern European	1	1	-
French	1	1	1
French Canadian	-	-	1
German	7	1	4
Hispanic	2	-	-
Hungarian	2	-	-
Irish	6	1	4
Irish Catholic	-	3	-
Italian	1	1	-
Jewish	5	3	1
Midwest	-	1	1
New England	-	1	-
Northern	-	-	1
Protestant	-	1	-
Rural	-	-	1
Russian	2	-	-
Scandinavian	5	1	1
Scot	4	-	2
Southern	4	2	3
Spanish	1	-	-
Urban	-	3	-

Evaluation of Hypotheses Based on the Myers-Briggs Type Indicator and the Adjective Check List

Table 4.11 provides the type preferences of therapists from the Process model, Structural model, and Systems model. Among Process model therapists, Intuitive types (90.90%, $n=40$) and Feeling types (68.18%, $n=30$) were notable. Among Structural model therapists, Introverted types (75.00%, $n=12$), Intuitive types (81.25%, $n=13$), and Judging types (68.75%, $n=11$) were notable. Among Systems model therapists, Introverted types (75.00%, $n=12$), Intuitive types (93.75%, $n=15$), Thinking types (100%, $n=16$), and Judging types (97.50%, $n=14$) were notable.

$H_{(R)}^1$ There will be statistically significant differences in psychological type preference on the Extroversion-Introversion scale among therapists from the Process, Structural, and Systems models.

The hypothesis stating the existence of significant differences in psychological type preference among therapists from the Process, Structural, and Systems models was rejected. A summary of the results obtained by analysis of variance is presented in Table 4.12. On the variable Extroversion-Introversion, an $F(2, 73) = 1.83$, $p < .1684$ was obtained. Since the .05 level of significance was used

and not reached, the hypothesis was rejected. On the Extroversion-Introversion scale the group means were as follows: Process model (100.96), Structural model (111.50), and Systems model (112.50).

$H_{(R)2}$ There will be statistically significant differences in psychological type preference on the Sensation-Intuition scale among therapists from the Process, Structural, and Systems models.

The hypothesis stating the existence of significant differences in psychological type preference among therapists from the Process, Structural, and Systems models was rejected. A summary of the results obtained by analysis of variance is presented in Table 4.12. On the variable Sensation-Intuition, an $F(2, 73) = 1.28$, $p < .2839$ was obtained. Since the .05 level of significance was used and not reached, the hypothesis was rejected. On the Sensation-Intuition scale the group means were as follows: Process model (124.55), Structural model (115.50), and Systems model (112.88).

$H_{(R)3}$ There will be statistically significant differences in psychological type preference on the Thinking-Feeling scale among therapists from the Process, Structural, and Systems models.

The hypothesis stating the existence of significant differences in psychological type preference on the Thinking-Feeling scale among therapists from the Process, Structural, and Systems models was accepted. A summary of the results obtained by analysis of variance is presented in Table 4.12. On the variable Thinking-Feeling, an $F(2, 73) = 2.52, p < .0001$ was obtained. Since the .05 level of significance was used and reached, the hypothesis was accepted. On the variable Thinking-Feeling the group means were as follows: Process model (109.32), Structural model (97.00), and Systems model (68.75).

A post hoc analysis using Scheffe's t multiple range test was conducted in order to specify which of the three sample means differed significantly from one another. A significant difference at the $p < .05$ level was reached between the Systems model and the Process model, and between the Systems model and the Structural model. Therefore, there are differences in Thinking-Feeling preference (according to the MBTI) between therapists from the Systems model and the Process model, and between therapists from the Systems model and the Structural model.

- H_{(R)4} There will be statistically significant differences in psychological type preference on the Judging-Perception scale among therapists from the Process, Structural, and Systems models.

The hypothesis stating the existence of significant differences in psychological type preference on the Judging-Perceiving scale among therapists from the Process, Structural, and Systems models was accepted. A summary of the results obtained by analysis of variance is presented in Table 4.12. On the variable Judging-Perceiving, an $F(2, 73) = 7.56, p < .001$ was obtained. Since the .05 level of significance was used and reached, the hypothesis was accepted. On the variable Judging-Perceiving the group means were as follows: Process model (105.64), Structural model (87.75), and Systems model (78.63).

A post hoc analysis using Scheffe's t multiple range test was conducted in order to specify which of the three sample means differed significantly from one another. A significant difference at the $p < .05$ level was reached between the Systems model and the Process model. Therefore, there are statistically significant differences on Thinking-Feeling preference (according to the MBTI) between therapists from the Systems model and therapists from the Process model.

- H_{(R)5} There will be statistically significant differences in personality attributes according to the Achievement scale among therapists from the Process, Structural, and Systems models.

The hypothesis stating the existence of significant differences in personality attributes according to the Achievement scale among therapists from the Process, Structural, and Systems models was rejected. A summary of the results obtained by analysis of variance is presented in Table 4.12. On the variable Achievement, an $F(2, 74) = 2.35$, $p < .7912$ was obtained. Since the .05 level of significance was used and not reached, the hypothesis is rejected. On the Achievement scale the group means were as follows: Process model (54.11), Structural model (55.31), and Systems model (53.41).

- H_{(R)6} There will be statistically significant differences in personality attributes according to the Dominance scale among therapists from the Process, Structural, and Systems models.

The hypothesis stating the existence of significant differences in personality attributes according to the Dominance scale among therapists from the Process, Structural, and Systems models was rejected. A summary of

the results obtained by analysis of variance is presented in Table 4.13. On the variable Dominance, an $F(2, 74) = 1.45$, $p < .2424$ was obtained. Since the .05 level of significance was used and not reached, the hypothesis is rejected. On the Dominance scale the group means were as follows: Process model (54.52), Structural model (52.50), and Systems model (50.24).

$H_{(R)7}$ There will be statistically significant differences in personality attributes according to the Endurance scale among therapists from the Process, Structural, and Systems models.

The hypothesis stating the existence of significant differences in personality attributes according to the Endurance scale among therapists from the Process, Structural, and Systems models was rejected. A summary of the results obtained by analysis of variance is presented in Table 4.13. On the variable Endurance, an $F(2, 74) = 7.54$, $p < .4742$ was obtained. Since the .05 level of significance was used and not reached, the hypothesis is rejected. On the Endurance scale the group means were as follows: Process model (51.46), Structural model (53.44), and Systems model (53.82).

- $H_{(R)8}$ There will be statistically significant differences in personality attributes according to the Order scale among therapists from the Process, Structural, and Systems models.

The hypothesis stating the existence of significant differences in personality attributes according to the Order scale among therapists from the Process, Structural, and Systems models was rejected. A summary of the results obtained by analysis of variance is presented in Table 4.13. On the variable Order, an $F(2, 74) = 1.13$, $p < .3282$ was obtained. Since the .05 level of significance was used and not reached, the hypothesis is rejected. On the Order scale the group means were as follows: Process model (50.30), Structural model (53.13), and Systems model (53.71).

- $H_{(R)9}$ There will be statistically significant differences in personality attributes according to the Nurturance scale among therapists from the Process, Structural, and Systems models.

The hypothesis stating the existence of significant differences in personality attributes according to the Nurturance scale among therapists from the Process, Structural, and Systems models was rejected. A summary of the results obtained by analysis of variance is

presented in Table 4.13. On the variable Nurturance, an $F(2, 74) = 2.26$, $p < .1118$ was obtained. Since the .05 level of significance was used and not reached, the hypothesis is rejected. On the Nurturance scale the group means were as follows: Process model (55.39), Structural model (51.69), and Systems model (51.77).

$H_{(R)10}$ There will be statistically significant differences in personality attributes according to the Autonomy scale among therapists from the Process, Structural, and Systems models.

The hypothesis stating the existence of significant differences in personality attributes according to the Autonomy scale among therapists from the Process, Structural, and Systems models was rejected. A summary of the results obtained by analysis of variance is presented in Table 4.13. On the variable Autonomy, an $F(2, 74) = 2.22$, $p < .1157$ was obtained. Since the .05 level of significance was used and not reached, the hypothesis is rejected. On the Autonomy scale the group means were as follows: Process model (52.10), Structural model (50.06), and Systems model (46.71).

- $H_{(R)11}$ There will be statistically significant differences in personality attributes according to the Change scale among therapists from the Process, Structural, and Systems models.

The hypothesis stating the existence of significant differences in personality attributes according to the Change scale among therapists from the Process, Structural, and Systems models was rejected. A summary of the results obtained by analysis of variance is presented in Table 4.13. On the variable Change, an $F(2, 74) = 1.99$, $p < .1442$ was obtained. Since the .05 level of significance was used and not reached, the hypothesis is rejected. On the Change scale the group means were as follows: Process model (52.25), Structural model (47.44), and Systems model (48.00).

- $H_{(R)12}$ There will be statistically significant differences in personality attributes according to the Self-Confidence scale among therapists from the Process, Structural, and Systems models.

The hypothesis stating the existence of significant differences in personality attributes according to the Self-Confidence scale among therapists from the Process, Structural, and Systems models was rejected. A summary

of the results obtained by analysis of variance is presented in Table 4.13. On the variable Self-Confidence, an $F(2, 74) = 5.99$, $p < .5518$ was obtained. Since the .05 level of significance was used and not reached, the hypothesis is rejected. On the Self-Confidence scale the group means were as follows: Process model (49.34), Structural model (48.56), and Systems model (51.77).

$H_{(R)13}$ There will be statistically significant differences in personality attributes according to the Self-Control scale among therapists from the Process, Structural, and Systems models.

The hypothesis stating the existence of significant differences in personality attributes according to the Self-Control scale among therapists from the Process, Structural, and Systems models was rejected. A summary of the results obtained by analysis of variance is presented in Table 4.13. On the variable Self-Control, an $F(2, 74) = 1.14$, $p < .3252$ was obtained. Since the .05 level of significance was used and not reached, the hypothesis is rejected. On the Self-Control scale the group means were as follows: Process model (56.93), Structural model (53.06), and Systems model (54.94).

- H_(R)14 There will be statistically significant differences in personality attributes according to the Personal Adjustment scale among therapists from the Process, Structural, and Systems models.

The hypothesis stating the existence of significant differences in personality attributes according to the Personal Adjustment scale among therapists from the Process, Structural, and Systems models was rejected. A summary of the results obtained by analysis of variance is presented in Table 4.13. On the variable Personal Adjustment, an $F(2, 74) = 1.36$, $p < .2637$ was obtained. Since the .05 level of significance was used and not reached, the hypothesis is rejected. On the Personal Adjustment scale the group means were as follows: Process model (55.52), Structural model (51.69), and Systems model (54.65).

Table 4.11

Type Preferences of Ss by Model

Model	E of Ss	Percent I of Ss	Percent S of Ss	Percent N of Ss	Percent T of Ss	Percent F of Ss	Percent J of Ss	Percent P of Ss	Total n
Process	23 52.27%	21 47.73%	4 9.09%	40 90.90%	14 31.82%	30 68.18%	21 47.73%	23 52.27%	44
Structural	4 25.00%	12 75.00%	3 18.75%	13 81.25%	9 56.25%	7 43.75%	11 68.75%	5 31.25%	16
Systems	4 25.00%	12 75.00%	1 6.25%	15 93.75%	16 100.00%	0	14 87.50%	2 12.50%	16

Table 4.12

Summary of Analysis of Variance on Myers-Briggs Type Indicator Scales

Variable	Source of Variance	Sum of Squares	df	F	p
Extroversion-Introversion (E-I)	Between Groups	2268.25	2	1.83	.1684
	Within Groups	45355.91	73		
	Total	47624.16	75		
Sensing-Intuition (S-N)	Between Groups	968.97	2	1.28	.2839
	Within Groups	27550.66	73		
	Total	28517.63	75		
Thinking-Feeling (T-F)	Between Groups	19338.87	2	2.52	.0001 ^a
	Within Groups	28062.55	73		
	Total	47401.42	75		
Judging-Perceiving (J-P)	Between Groups	10002.49	2	7.56	.0010 ^a
	Within Groups	48294.93	73		
	Total	58297.42	75		

Note: The ANOVA results shown are based on data obtained from Ss representing three models of family therapy: Group 1 (Process model), Group 2 (Structural model), and Group 3 (Systems model).

^a The T-F scales and the J-P scales were significant at the $p < .05$ level.

Table 4.13

Summary of Analysis of Variance on Adjective Checklist
Scales

Variable	Source of Variance	Sum of Squares	df	F	p ^a
Achievement	Between Groups	30.69	2	2.35	.7912
	Within Groups	4833.99	74		
	Total	4864.68	76		
Dominance	Between Groups	234.09	2	1.45	.2424
	Within Groups	5996.04	74		
	Total	6230.13	76		
Endurance	Between Groups	90.99	2	7.54	.4742
	Within Groups	4467.32	74		
	Total	4558.31	76		
Order	Between Groups	187.38	2	1.13	.3282
	Within Groups	6130.44	74		
	Total	6317.82	76		
Nurturance	Between Groups	252.53	2	2.26	.1118
	Within Groups	4138.93	74		
	Total	4391.46	76		
Autonomy	Between Groups	359.12	2	2.22	.1157
	Within Groups	5984.10	74		
	Total	6343.22	76		
Change	Between Groups	388.33	2	1.99	.1442
	Within Groups	7226.19	74		
	Total	7614.52	76		
Self-Confidence	Between Groups	98.83	2	5.99	.5518
	Within Groups	6100.88	74		
	Total	6199.71	76		
Self-Control	Between Groups	187.85	2	1.14	.3252
	Within Groups	6094.67	74		
	Total	6282.52	76		
Personal Adjustment	Between Groups	172.87	2	1.36	.2637
	Within Groups	4712.30	74		
	Total	4885.17	76		

Note: The ANOVA results shown are based on data obtained from Ss representing three models of family therapy: Group 1 (Process model), Group 2 (Structural model), and Group 3 (Systems model).

^a Using the $p < .05$ level, none of the F values were significant.

Examination of Data from the Nodal Events Survey

Respondents were asked to complete the Nodal Events Survey (NES) for their own family of origin experience. Adoptive respondents were asked to complete the instrument for their adoptive family experience. There were three adopted Ss among the 76 Ss who completed the NES. The ages at adoption of these Ss was reported as 11 years; six months, and one respondent did not record his/her age. Data collected from the NES is presented on the basis of descriptive statistics. Differences were not examined according to statistical significance. Some variance in the *n* of each model occurred due to incomplete instrument return. Therefore, the total on which data is reported from the NES is 44 Ss from the Process model, 15 Ss from the Structural model, and 17 Ss from the Systems model.

Events for which no age was given, or for which a "B" (before birth) was recorded, were not counted. Likewise, information about the subject's family of procreation (i.e., husbands, children) was not counted. Respondents were asked in two different places on the NES to indicate other events which they considered significant in their lives, or other issues which they considered to be significant in their family of origin as it might affect their approach to psychotherapy. The information from these questions was

used as a check on the other questions asked in the instrument and are not reported separately here. Notable differences will be highlighted in this section; however, the reader is referred to the accompanying tables for more detailed information.

- H_(R)15 There will be differences in total death events indicated on the Deaths in Family scale among therapists from the Process, Structural, and Systems models.

Due to the occurrence of missing data, inconsistent reporting, and the small and unequal sample sizes, a report of the total death events on the Deaths in Family Scale among Ss from the Process, Structural, and Systems models is considered inappropriate and misleading.

- H_(R)16 There will be differences in the occurrence of death events associated with specific family members according to the Deaths in Family scale among therapists from the Process, Structural, and Systems models.

The hypothesis of differences in the occurrence of death events associated with specific family members among Ss from the Process, Structural, and Systems models is accepted. Results for this hypothesis are reported in Table 4.14. Nearly half (47.7%, $n=21$) of the Ss from the Process model reported experiencing the death of their mothers.

Less than one-fourth of the Ss from the Structural (13.3%, $n=2$) and Systems (17.7%, $n=3$) models had experienced the deaths of their mothers. While the death of a sister was reported by Ss from the Process (6.8%, $n=3$) and Systems (5.9%, $n=1$) models, Ss from the Structural model reported no deaths of sisters.

$H_{(R)17}$ There will be differences in therapist's ages at the occurrence of death events associated with specific family members according to the Deaths in Family scale among therapists from the Process, Structural, and Systems models.

The hypothesis of differences in subject ages at the occurrence of death events associated with specific family members among Ss from the Process, Structural, and Systems models is accepted. Results for this hypothesis are reported in Table 4.14. Most notable among this data is the young age ($X = 17.0$ years) at which Ss from the Structural experienced the death of a brother. There were no reports of the death of a brother among Ss from the Systems model, and the mean age at which Ss from the Process model experienced the death of a brother was in their adulthood ($X = 33.3$ years).

- H_(R)18 There will be differences in the total occurrence of suicide events indicated on the Deaths in Family scale among therapists from the Process, Structural, and Systems models.

The hypothesis of differences in the total occurrence of suicide events in the families of origin of Ss from the Process, Structural, and Systems models is rejected. Results for this hypothesis are reported in Table 4.14. The experience of suicide by a member of one's family of origin occurred at a similar rate across all three models: Process model (13.6%, $n=6$), Structural model (13.3%, $n=2$), and Systems model (17.7%, $n=3$).

- H_(R)19 There will be differences in the total occurrence of murder events indicated on the Deaths in Family scale among therapists from the Process, Structural, and Systems models.

The hypothesis of differences in the occurrence of murder events in the families of origin of Ss from the Process, Structural, and Systems models is accepted. Results for this hypothesis are reported in Table 4.14. While there were no recorded murder events among the families of Ss from the Process and Structural models, there was one reported murder in the family of origin of a Systems model subject.

- $H_{(R)20}$ There will be differences of the family members who died as the result of suicide on the Deaths in Family scale among therapists from the Process, Structural, and Systems models.

The hypothesis of differences in the family members who committed suicide in the families of origin of Ss from the Process, Structural, and Systems models is accepted.

Results for this hypothesis are reported in Table 4.14.

While the specific family member who committed suicide was different in each model, there was some similarity across the models. Of the 11 reported family members who committed suicide, only three were from the nuclear families of the Ss. The other eight suicides were uncles, cousins, aunts, and great aunts.

- $H_{(R)21}$ There will be differences in the therapist's ages at the death of family members who died as the result of suicide on the Deaths in Family scale among therapists from the Process, Structural, and Systems models.

The hypothesis of differences in subject ages at the death of a family member who committed suicide is accepted. Results for this hypothesis are reported in Table 4.14. Ss from the Process model and Systems model who experienced a suicide event in their families of origin did so at a mean

age in young adulthood: Process model ($X = 24.8$ years), and Systems model ($X = 25.7$ years). However, Ss from the Structural model experienced this suicide event as teenagers: $X = 14.5$ years.

- $H_{(R)22}$ There will be differences in the family members who died as the result of murder on the Deaths in Family scale among therapists from the Process, Structural, and Systems models.

The hypothesis of differences in family members who were victims of murder in the families of origin of Ss from the Process, Structural, and Systems models is accepted. Results for this hypothesis are reported in Table 4.14. One murder event was reported; a cousin of a subject from the Systems model. There were no reported murder events among subject families from the Process and Structural models.

- $H_{(R)23}$ There will be differences in the therapist's ages at the death of family members who died as the result of murder on the Deaths in Family scale among therapists from the Process, Structural, and Systems models.

The hypothesis of differences in subject's ages at the death of a family member by murder is accepted. Results for this hypothesis are reported in Table 4.14. The murder of one reported family member was experienced by the subject

(Systems model) at age 40 years. There were no reported murder events among therapist families from the Process and Structural models.

- H_(R)24 There will be differences in the total occurrence of family separations on the Separations in Family scale among therapists from the Process, Structural, and Systems models.

The hypothesis of differences in the total occurrence of family separations in the families of origin of Ss from the Process, Structural, and Systems models is accepted. Results for this hypothesis are reported in Table 4.15. One fourth (25.0%, $n=11$) of the Ss from the Process model experienced a family separation; 11.8% ($n=2$) of Ss from the Systems model experienced a family separation; there were no reported family separations among Structural model Ss.

- H_(R)25 There will be differences in the occurrence of whole families who split up on the Separations in Family scale among therapists from the Process, Structural, and Systems models.

The hypothesis of differences in the occurrence of whole families who split up in the families of origin of Ss from the Process, Structural, and Systems models is accepted. Results from this hypothesis are reported in

Table 4.15. Ss from the Structural and Systems models reported no experience of whole families splitting up. There was one report of a whole family split among Ss from the Process model.

- H_(R)26 There will be differences in the therapist's ages when whole families who split up on the Separations in Family scale among therapists from the Process, Structural, and Systems models.

The hypothesis of differences in subject's ages when their families split up among Ss from the Process, Structural, and Systems models is accepted. Results for this hypothesis are reported in Table 4.15. The one reported occurrence of a family splitting up (Process model) occurred when the subject was three years old. Ss from the Structural and Systems models reported no experience of whole families splitting up.

- H_(R)27 There will be differences in the occurrence of parental separation as indicated on the Separations in Family scale among therapists from the Process, Structural, and Systems models.

The hypothesis of differences in the occurrence of parental separations among Ss from the Process, Structural, and Systems models is accepted. Results for this hypothesis

are reported in Table 4.15. There were no reported parental separations in the families of origin of Structural model Ss. Parental separation were reported in the families of origin of Process model Ss (18.2%, $n=8$) and Systems model Ss (11.8%, $n=2$).

$H_{(R)28}$ There will be differences in the therapist's ages when parents separated as indicated on the Separations in Family scale among therapists from the Process, Structural, and Systems models.

The hypothesis of differences in subject's ages when their parents separated is accepted. Results for this hypothesis are reported in Table 4.15. There were no reported parental separations by Ss from the Structural model. Ss from the Process and Systems models experienced parental separation as teenagers and children: Process model (X age = 13.8 years), Systems model (X age = 7.5 years).

$H_{(R)29}$ There will be differences in the occurrence of parental desertion as indicated on the Separations in Family scale among therapists from the Process, Structural, and Systems models.

The hypothesis of differences in the occurrence of parental desertion in the families of origin of Ss from the Process, Structural, and Systems models is accepted. Results for this hypothesis are reported in Table 4.15. Parental desertion was reported two times (4.6%) by Ss from the Process model. There was no report of parental desertion in the families of origin of Ss from the Structural and Systems models.

- H_(R)30 There will be differences in the therapist's ages when parental desertion occurred as indicated on the Separations in Family scale among therapists from the Process, Structural, and Systems models.

The hypothesis of differences in subject ages when parental desertion occurred among Ss from the Process, Structural, and Systems models is accepted. Results for this hypothesis are reported in Table 4.15. The two reported occurrences of parental desertion in the families of origin of Process model Ss yielded a mean age at occurrence of 8.5 years. There were no reported parental desertions in the families of origin of Structural and Systems model Ss.

- H_(R)31 There will be differences in the total occurrence of serious illness associated with specific family members according to the Serious Illness in Family scale among therapists from the Process, Structural, and Systems models.

Due to the occurrence of missing data, inconsistent reporting, and the small and unequal sample sizes, a report of the total serious illness events on the Serious Illness in Family scale among Ss from the Process, Structural, and Systems models is considered inappropriate and misleading.

- H_(R)32 There will be differences in the occurrence of serious illness associated with specific family members according to the Serious Illness in Family scale among therapists from the Process, Structural, and Systems models.

The hypothesis of differences in occurrence of serious illness associated with specific family members among Ss from the Process, Structural, and Systems models is accepted. Results for this hypothesis are reported in Table 4.16. Nearly half (45.5%, $n=20$) of the Ss from the Process model reported the serious illness of their mothers, compared to 20.0% ($n=3$) of Ss from the Structural model and 29.4% ($n=5$) of Ss from the Systems model. The serious illness of fathers was reported by 40% ($n=6$) of Structural

model Ss, 34.1% ($n=15$) of Process model Ss, and 23.5% ($n=4$) of Systems model Ss. Additionally, 15.9% ($n=7$) of Ss from the Process model, and 17.7% ($n=3$) of Ss from the Systems model reported experiencing serious illness themselves. There were no reports of serious illness (of themselves) among Ss from the Structural model.

H_{(R)33} There will be differences in the therapist's ages when a serious illness associated with specific family members occurred according to the Serious Illness in Family scale among therapists from the Process, Structural, and Systems models.

The hypothesis of differences in subject's ages when a serious illness occurred in their families of origin is accepted. Results for this hypothesis are reported in Table 4.16. Ss from the Process and Structural models experienced the serious illness of their mothers as adults: Process model (X age = 30.9 years), Structural model (X age = 22.3 years). In contrast, Ss from the Systems model experienced the serious illness of their mothers during adolescence (X age = 16.8 years). Some Ss across the three models experienced the serious illness of their fathers as adults: Process model (X age = 28.3 years), Structural model (X age = 26.7 years), Systems model (X age = 32.3 years). Another noted difference occurs concerning the serious

illness of brothers of the Ss who participated in this study. Ss from the Process model experienced the serious illness of their brothers as adults (X age = 33.4 years); Ss from the Systems model experienced the serious illness of their brothers as pre-adolescents (X age = 12.5 years); there were no reports of serious illness of brothers of Ss from the Structural model. Data revealed differences among Ss from the three models on the experience of serious illness themselves. Process model Ss reported the experience of serious illness by themselves as adults (X age = 28.3 years), whereas System model Ss reported the experience of serious illness by themselves in adolescence (X age = 17.0 years). Structural model Ss reported no experience of serious illness for themselves.

H(R)34 There will be differences in the total occurrence of disability/handicapped conditions on the Family Member Disabled or Handicapped scale among therapists from the Process, Structural, and Systems models.

Due to the occurrence of missing data, inconsistent reporting, and the small and unequal sample sizes, a report of the total occurrence of disability/handicapped conditions in the families of origin of Ss from the Process, Structural, and Systems models is considered inappropriate and misleading.

- H_(R)35 There will be differences in the occurrence of disability/handicapped conditions associated with specific family members according to the Family Member Disabled or Handicapped scale among therapists from the Process, Structural, and Systems models.

The hypothesis of differences in the occurrence of disability/handicapped conditions associated with specific family members among Ss from the Process, Structural, and Systems models is accepted. Results for this hypothesis are reported in Table 4.17. Notable is the occurrence of disability/handicapped conditions of mothers of Ss from the three models. While 9.1% (n=4) of Ss from the Process model reported the occurrence of disability/handicapped conditions of their mothers, there were no reported disability/handicapped conditions of the mothers of Ss from the Structural and Systems models. Similarly, while 6.8% (n=3) of Ss from the Process model reported the occurrence of disability/handicapped conditions of their brothers, there were no reported disability/handicapped conditions of the brothers of Ss from the Structural and Systems models. Some Ss across the models reported the disability/handicapped condition of a father: Process model (4.6%, n=2), Structural model (20.0%, n=3), Systems model (5.9%, n=1).

- $H_{(R)36}$ There will be differences in the therapist's ages when a disability/handicapped condition associated with specific family members occurred according to the Family Member Disabled or Handicapped scale among therapists from the Process, Structural, and Systems models.

The hypothesis of differences in subject's ages when a disability/handicapped conditions associated with specific family members occurred is accepted. Results of this hypothesis are reported in Table 4.17. Notable is the differing ages when Ss experienced the disability/handicapped condition of their fathers. While Ss from the Structural and Systems models experienced this event as adults (Structural: X age = 22.7 years; Systems: X age = 40.0 years), Process model Ss experienced their father's disability/handicapped condition as small children (X age = 2.5 years).

- $H_{(R)37}$ There will be differences in the total occurrence of institutionalization on the Family Member Placed in Institution scale among therapists from the Process, Structural, and Systems models.

Due to the occurrence of missing data, inconsistent reporting, and the small and unequal sample sizes, a report of the total occurrence of institutionalization of members of the families of origin of Ss from the Process, Structural, and Systems models is considered inappropriate and misleading.

H_(R)38 There will be differences in the occurrence of institutionalization on the Family Member Placed in Institution scale among therapists from the Process, Structural, and Systems models.

The hypothesis of differences in occurrence of institutionalization of members of the families of origin of Ss from the Process, Structural, and Systems models is accepted. Results are reported in Table 4.18. The institutionalization of mothers of Ss were reported in the Process (4.6%, n=2) and Systems (5.9%, n=1) models; however, there were no reports of institutionalization of fathers among Ss from the Systems model. Only Ss from the Process model reported the institutionalization of a sister (2.3%, n=1) or brother (6.8%, n=3). Likewise, only Ss from the Process model reported their own institutionalization (4.6%, n=2).

- H_{(R)39} There will be differences in the therapist's ages when an institutionalization associated with specific family members occurred according to the Family Member Placed in Institution scale among therapists from the Process, Structural, and Systems models.

The hypothesis of differences in subject's ages when a family member was institutionalized is accepted. Results for this hypothesis are reported in Table 4.18. Most of the experiences of institutionalization of a family member occurred, among Ss from all three models, when the Ss were children or adolescents. However, Ss from the Process model reported experiencing this institutionalization also as adults: \bar{X} age = 38.0 years regarding the institutionalization of their mothers; \bar{X} age = 37.0 years regarding the institutionalization of another significant family member.

- H_{(R)40} There will be differences in the total occurrence of moving events on the Moving Events scale among therapists from the Process, Structural, and Systems models.

The hypothesis of differences in the total occurrence of moving events among Ss from the Process, Structural, and Systems models is accepted. Results for this hypothesis are reported in Table 4.19. Process model Ss moved more often

than Ss from the Structural and Systems models: Process model (X moves = 5.3 times), Structural model (X moves = 1.9 times), Systems model (X moves = 2.3 times).

H_{(R)41} There will be differences in the occurrence of moves within the same general area on the Moving Events scale among therapists from the Process, Structural, and Systems models.

The hypothesis of differences in the occurrence of moves within the same general area among Ss from the Process, Structural, and Systems models is accepted. Results for this hypothesis are reported in Table 4.19. Process model subjects had moved more often within the same area than Ss from the Structural and System models: Process model (X moves = 3.5 times), Structural model (X moves = .9 times), Systems model (X moves = 1.8 times).

H_{(R)42} There will be differences in the occurrence of moves to another state on the Moving Events scale among therapists from the Process, Structural, and Systems models.

The hypothesis of differences in the occurrence of moves to another state among Ss from the Process, Structural, and Systems models is rejected. Results for this hypothesis are reported in Table 4.19. The mean times that Ss moved to another state was similar across all three models.

- H_{(R)43} There will be differences in the occurrence of moves to another geographic region on the Moving Events scale among therapists from the Process, Structural, and Systems models.

The hypothesis of differences in the occurrence of moves to another geographic region among Ss from the Process, Structural, and Systems models is rejected. Results for this hypothesis are reported in Table 4.19. The mean times that Ss moved to another geographic region was similar across all three models.

- H_{(R)44} There will be differences in the occurrence of moves to another country on the Moving Events scale among therapists from the Process, Structural, and Systems models.

The hypothesis of differences in the occurrence of moves to another country among Ss from the Process, Structural, and Systems models is rejected. Results for this hypothesis are reported in Table 4.19. The mean times that Ss moved to another country was similar across all three models.

- H_{(R)45} There will be differences in the total occurrence of alcohol abuse on the Alcohol Abuse scale among therapists from the Process, Structural, and Systems models.

Due to the occurrence of missing data, inconsistent reporting, and the small and unequal sample sizes, a report of the total occurrence of alcohol abuse in the families of origin of Ss from the Process, Structural, and Systems models is considered inappropriate and misleading.

H_(R)46 There will be differences in the occurrence of alcohol abuse associated with specific family members on the Alcohol Abuse scale among therapists from the Process, Structural, and Systems models.

The hypothesis of differences in the occurrence of alcohol abuse associated with specific family members of Ss from the Process, Structural, and Systems models is accepted. Results for this hypothesis are reported in Table 4.20. Alcohol abuse by fathers of Ss was reported more often by Process and Structural model Ss than Systems model Ss: Process model (22.7%, $n=10$), Structural model (26.7%, $n=4$), Systems model (11.8%, $n=2$). Alcohol abuse by mothers was reported more frequently among Structural and Systems model Ss than Process model Ss: Structural model (26.7%, $n=4$), Systems model (17.7%, $n=3$), Process model (2.3%, $n=1$). Alcohol abuse by a sibling was more frequently reported by Structural model Ss (33.3%, $n=5$) than Process model (15.9%, $n=7$) and Systems model (11.8%, $n=2$) Ss. The incidence of alcohol abuse by the subject was reported more often by

Structural model Ss (20.0%, $n=3$) than Process model (6.8%, $n=3$) and Systems model (5.9%, $n=1$) Ss.

$H_{(R)47}$ There will be differences in the total occurrence of drug abuse on the Drug Abuse scale among therapists from the Process, Structural, and Systems models.

Due to the occurrence of missing data, inconsistent reporting, and the small and unequal sample sizes, a report of the total occurrence of drug abuse in the families of origin of Ss from the Process, Structural, and Systems models is considered inappropriate and misleading.

$H_{(R)48}$ There will be differences in the occurrence of drug abuse associated with specific family members on the Drug Abuse scale among therapists from the Process, Structural, and Systems models.

The hypothesis of differences in the occurrence of drug abuse associated with specific family members in the families of origin of Ss from the Process, Structural, and Systems models is accepted. Results for this hypothesis are reported in Table 4.21. Drug abuse by a family member was reported more frequently by Structural model Ss than Process and Systems model Ss. Drug abuse by fathers was reported by Structural model Ss at 13.3% ($n=2$), by Systems model Ss at 5.9% ($n=1$), and not reported by Process model Ss. Drug

abuse by mothers of Ss was reported by 13.3% ($n=2$) of the Structural model Ss, 9.1% ($n=4$) of the Process model Ss and 5.9% ($n=1$) , and by Process Model Ss at 4.6%, ($n=2$). Drug abuse by the Ss themselves was reported at 20.0% ($n=3$) of Structural model Ss, 11.8% ($n=2$) of Systems model Ss, and 2.3% ($n=1$) of Process model Ss.

H_{(R)49} There will be differences in the total occurrence of physical/emotional abuse on the Physical/Emotional Abuse scale among therapists from the Process, Structural, and Systems models.

Due to the occurrence of missing data, inconsistent reporting, and the small and unequal sample sizes, a report of the total occurrence of physical/emotional abuse in the families of origin of Ss from the Process, Structural, and Systems models is considered inappropriate and misleading.

H_{(R)50} There will be differences in the occurrence of physical/emotional abuse between parents on the Physical/Emotional Abuse scale among therapists from the Process, Structural, and Systems models.

The hypothesis of difference in the occurrence of physical/emotional abuse between parents in the families of origin of Ss from the Process, Structural, and Systems models is accepted. Results for this hypothesis are

reported in Table 4.22. Physical/emotional abuse between parents occurred in nearly half of the families of Structural model Ss (46.7%, $n=7$), compared with those of the Systems model Ss (23.5%, $n=4$), and the Process model (15.9%, $n=7$).

H_(R)51 There will be differences in the occurrence of physical/emotional abuse between parent and child on the Physical/Emotional Abuse scale among therapists from the Process, Structural, and Systems models.

The hypothesis of difference in occurrence of physical/emotional abuse between parent and child in the families of origin of Ss from the Process, Structural, and Systems models is accepted. Results for this hypothesis are reported in Table 4.22. Physical/emotional abuse between parent and child occurred in nearly half of the families of Structural model Ss (46.7%, $n=7$), compared with those of Process model Ss (18.2%, $n=8$), and Systems model Ss (5.9%, $n=1$).

H_(R)52 There will be differences in the occurrence of physical/emotional abuse involving the therapist in his/her family of origin on the Physical/ Emotional Abuse scale among therapists from the Process, Structural, and Systems models.

The hypothesis of difference in the occurrence of physical/emotional abuse involving the subject (as the subject of abuse) in the families of origin of Ss from the Process, Structural, and Systems models is accepted. Results for this hypothesis are reported in Table 4.22. Physical/emotional abuse involving the subject occurred more frequently in families of Structural model Ss (33.3%, $n=5$), than in those of Process model (20.5%, $n=9$), and Systems model Ss (5.9%, $n=1$).

$H_{(R)53}$ There will be differences in the total occurrence of financial deprivation in their family of origin among therapists from the Process, Structural, and Systems models.

The hypothesis of difference in the total occurrence of financial deprivation in the families of origin of Ss from the Process, Structural, and Systems models is accepted. Results for this hypothesis are reported in Table 4.23. No occurrence of financial deprivation in families of origin were reported by Systems model Ss. The occurrence of financial deprivation in families of origin of Ss from the Process and Structural models was similar: Process model (20.5%, $n=9$), Structural model (26.7%, $n=4$).

- $H_{(R)54}$ There will be differences in the total occurrence of parental difficulty in obtaining employment among therapists from the Process, Structural, and Systems models.

The hypothesis of difference in the total occurrence of parental difficulty in obtaining employment among Ss from the Process, Structural, and Systems models is accepted. Results for this hypothesis are reported in Table 4.23. No occurrences of parental employment difficulty were reported by Systems model Ss. The occurrence of parental difficulty obtaining employment reported by Process and Structural model Ss were similar: Process model (11.4%, $n=5$) and Structural model (13.3%, $n=2$).

- $H_{(R)55}$ There will be differences in the occurrence of parental employment which necessitated periods away from the family among therapists from the Process, Structural, and Systems models.

The hypothesis of difference in the occurrence of parental employment which necessitated periods away from the family of Ss from the Process, Structural, and Systems models is accepted. Results for this hypothesis are reported in Table 4.23. Nearly one-third (31.8%, $n=14$) of Process model Ss reported parental employment necessitating periods away from the family in their families of origin.

Nearly one-fourth (23.5%, $n=4$) of Systems model Ss reported parental employment necessitating periods away from the family in their families of origin. The occurrence of parental employment necessitating periods away from home occurred less frequently in the families of origin of Structural model Ss (6.7%, $n=1$).

H_(R)56 There will be differences in the length of time of parental employment which necessitated periods away from the family among therapists from the Process, Structural, and Systems models.

The hypothesis of difference in the length of time of parental employment which necessitated periods away from the family is rejected. Results for this hypothesis are reported in Table 4.23. The mean periods of time away from the family which were caused by parental employment were similar across the three models.

H_(R)57 There will be differences in which parenting adult was involved of therapists whose parent's employment necessitated periods away from the family among therapists from the Process, Structural, and Systems models.

The hypothesis of difference of parenting adult whose employment necessitated periods away from the family among Ss from the Process, Structural, and Systems models is

accepted. Results for this hypothesis are reported in Table 4.24. The mother was reported by Ss as the parenting adult away from home due to employment in the Process model (9.1%, $n=4$), but not by either Structural or Systems model Ss. The father was more frequently named as the parenting adult whose employment caused periods away from home: Process model (22.7%, $n=10$), Systems model (17.7%, $n=3$), Structural model (6.7%, $n=1$). The absence of both parents due to employment was reported by only one (Systems model) subject and not any from the Process or Structural model Ss.

Table 4.14

Occurrence of Death Events in Family of Origin

Family Member	Process Model (n=44)			Structural Model (n=16)			Systems Model (n=17)		
	n	X age	Range	n	X age	Range	n	X age	Range
X age of subject at death of family member									
Father	30	34.8 yrs	12-61 yrs	8	32.6 yrs	6-62 yrs	6	32.0 yrs	11-56 yrs
Mother	21	38.2 yrs	9-66 yrs	2	21.5 yrs	8-35 yrs	3	39.0 yrs	24-56 yrs
Stepmother	4	48.3 yrs	42-57 yrs	-	-	-	-	-	-
Stepfather	1	29.0 yrs	-	-	-	-	-	-	-
Sister	3	55.6 yrs	45-68 yrs	-	-	-	1 ^c	39.0 yrs ^c	-
Brother	13	33.3 yrs	10-62 yrs	2	17.0 yrs	9-25 yrs	-	-	-
Grandmother (maternal)	25	19.6 yrs	1-43 yrs	10	23.6 yrs	6-35 yrs	13	21.2 yrs	12-32 yrs
Grandfather (maternal)	30	15.5 yrs	4-34 yrs	11	16.7 yrs	1-34 yrs	16	14.4 yrs	3-32 yrs
Grandmother (paternal)	27	20.4 yrs	1-58 yrs	11	17.0 yrs	6-38 yrs	10	18.0 yrs	5-42 yrs
Grandfather (paternal)	28	20.3 yrs	1-50 yrs	9	14.2 yrs	5-21 yrs	13	14.5 yrs	3-38 yrs
Other Significant Relative	12	30.4 yrs	16-53 yrs	2	40.0 yrs	35-45 yrs	4	34.5 yrs	30-37 yrs
By Suicide	6 ^a	24.8 yrs	10-46 yrs	2 ^b	14.5 yrs	11-18 yrs	3 ^c	25.7 yrs	16-37 yrs
By Murder	-	-	-	-	-	-	1 ^d	40.0 yrs	-

^a 2 great aunts, 2 uncles, 1 cousin, 1 mother^b 1 brother, 1 cousin^c 1 uncle, 1 cousin, 1 father^d 1 cousin

Table 4.15

Occurrence of Separations in Family of Origin

Type of Separation	X age of subject at time of family separation					
	Process Model (\bar{n} = 44)		Structural Model (\bar{n} = 16)		Systems Model (\bar{n} = 17)	
	\bar{n}	X age Range	\bar{n}	X age Range	\bar{n}	X age Range
Whole family split	1	3.0 yrs	-	-	-	-
Parental separation	8	13.6 yrs 1-33 yrs	-	-	2	7.5 yrs 6-9 yrs
Parental desertion	2	8.5 yrs 3-14 yrs	-	-	-	-
Total separation events	11				2	

Table 4.16

Occurrence of Serious Illness in Family of Origin

Family Member	Process Model ($n = 44$)			Structural Model ($n = 16$)			Systems Model ($n = 17$)		
	n	X age	Range	n	X age	Range	D	X age	Range
X age of subject at time of family member's illness									
Father	15	28.3 yrs	1-60 yrs	6	26.7 yrs	17-36 yrs	4	32.3 yrs	10-44 yrs
Mother	20	30.9 yrs	1-60 yrs	3	22.3 yrs	7-30 yrs	5	16.8 yrs	3-30 yrs
Stepmother	-	-	-	-	-	-	-	-	-
Stepfather	-	-	-	1	15.0 yrs	-	-	-	-
Sister	5	50.6 yrs	44-67 yrs	2	13.5 yrs	3-24 yrs	4	37.5 yrs	28-48 yrs
Brother	8	33.4 yrs	3-60 yrs	-	-	-	2	12.5 yrs	7-18 yrs
Grandmother (maternal)	8	12.5 yrs	2-23 yrs	1	6.0 yrs	-	5	19.6 yrs	10-31 yrs
Grandfather (maternal)	8	11.3 yrs	1-27 yrs	3	22.7 yrs	10-31 yrs	6	11.8 yrs	3-30 yrs
Grandmother (paternal)	7	19.6 yrs	8-32 yrs	2	10.0 yrs	6-14 yrs	4	22.0 yrs	16-34 yrs
Grandfather (paternal)	2	8.0 yrs	1-15 yrs	-	-	-	3	19.7 yrs	11-36 yrs
Other Significant Relative	3	23.3 yrs	1-39 yrs	-	-	-	2	39.0 yrs	36-42 yrs
Self	7	28.3 yrs	1-67 yrs	-	-	-	3	17.0 yrs	9-28 yrs

Table 4.17
Occurrence of Family of Origin Member Disabled or Handicapped

Family Member	Process Model (n = 44)			Structural Model (n = 16)			Systems Model (n = 17)		
	n	X age	Range	n	X age	Range	n	X age	Range
X age of subject at time of family member's disability									
Father	2	2.5 yrs	2-3 yrs	3	22.7 yrs	10-34 yrs	1	40 yrs	-
Mother	4	36.8 yrs	12-62 yrs	-	-	-	-	-	-
Stepmother	-	-	-	-	-	-	-	-	-
Stepfather	-	-	-	-	-	-	-	-	-
Sister	-	-	-	-	-	-	-	-	-
Brother	3	33.3 yrs	15-62 yrs	-	-	-	-	-	-
Grandmother (maternal)	2	17.5 yrs	15-20 yrs	1	27.0 yrs	-	1	10 yrs	-
Grandfather (maternal)	2	11.0 yrs	10-12 yrs	1	14.0 yrs	-	-	-	-
Grandmother (paternal)	-	-	-	1	27.0 yrs	-	-	-	-
Grandfather (paternal)	-	-	-	-	-	-	-	-	-
Other Significant Relative	-	-	-	-	-	-	-	-	-
Self	2	44.5 yrs	21-68 yrs	1	1.0 yrs	-	-	-	-

Table 4.18

Occurrence of Family of Origin Member Institutionalized

Family Member	Process Model (n = 44)				Structural Model (n = 16)				Systems Model (n = 17)			
	n	X age	Range	n	X age	Range	n	X age	n	X age	Range	n
X age of subject at time of family member's institutionalization												
Father	3	11.0 yrs	1-30 yrs	1	17.0 yrs	-	-	-	-	-	-	-
Mother	2	38.0 yrs	15-61 yrs	-	-	-	1	1.0 yrs	-	-	-	-
Stepmother	-	-	-	-	-	-	-	-	-	-	-	-
Stepfather	-	-	-	-	-	-	-	-	-	-	-	-
Sister	1	16.0 yrs	-	-	-	-	-	-	-	-	-	-
Brother	3	13.0 yrs	10-16 yrs	-	-	-	-	-	-	-	-	-
Grandmother (maternal)	-	-	-	-	-	-	1	15.0 yrs	-	-	-	-
Grandfather (maternal)	-	-	-	-	-	-	-	-	-	-	-	-
Grandmother (paternal)	-	-	-	-	-	-	-	-	-	-	-	-
Grandfather (paternal)	-	-	-	-	-	-	-	-	-	-	-	-
Other Significant Relative	1	37.0 yrs	-	-	-	-	1	2.0 yrs	-	-	-	-
Self	2	15.5 yrs	14-17 yrs	-	-	-	-	-	-	-	-	-
Total	12			1			3					

Table 4.19

Occurrence of Family Moves before Subject Reached Age 18 Years

Locale	Process Model ($\bar{n} = 44$)			Structural Model ($\bar{n} = 16$)			Systems Model ($\bar{n} = 17$)		
	\bar{n}	X moves	Range	\bar{n}	X moves	Range	\bar{n}	X moves	Range
Total Moves	41	5.3	0-40	15	1.9	0-5	17	2.3	0-7
Within Same Area	41	3.5	0-35	15	.9	0-3	17	1.8	0-6
To Another State	41	.8	0-8	15	.8	0-5	17	.3	0-2
To Another Region	41	.5	0-6	15	.3	0-3	17	.3	0-2
To Another Country	41	.5	0-7	15	.1	0-1	17	.1	0-1

Table 4.20

Occurrence of Alcohol Abuse in Family of Origin

Family Member	Process Model (<i>n</i> = 44)		Structural Model (<i>n</i> = 16)		Systems Model (<i>n</i> = 17)	
	<i>n</i>	Percent of total Ss	<i>n</i>	Percent of total Ss	<i>n</i>	Percent of total Ss
Father	10	22.7%	4	26.7%	2	11.8%
Mother	1	2.3%	4	26.7%	3	17.7%
Brother or Sister	7	15.9%	5	33.3%	2	11.8%
Self	3	6.8%	3	20.0%	1	5.9%
Other Significant Relative	10 ^a	22.7%	3 ^b	20.0%	7 ^c	41.2%

^a 2 uncles, 5 grandfathers, 3 grandmothers^b 1 uncle, 1 aunt, 1 grandfather^c 3 uncles, 2 grandfathers, 2 cousins

Table 4.21

Occurrence of Drug Abuse in Family of Origin

Family Member	Process Model ($n = 44$)		Structural Model ($n = 16$)		Systems Model ($n = 17$)	
	n	Percent of total Ss	n	Percent of total Ss	n	Percent of total Ss
Father	-	-	2	13.3%	1	5.9%
Mother	4	9.1%	2	13.3%	-	-
Brother or Sister	2	4.6%	2	13.3%	1	5.9%
Self	1	2.3%	3	20.0%	2	11.8%
Other Significant Relative	1 ^a	2.3%	-	-	-	-
^a 1 grandmother						

Table 4.22

Occurrence of Physical/Emotional Abuse in Family of Origin

Family Member	Process Model ($\bar{n} = 44$)		Structural Model ($\bar{n} = 16$)		Systems Model ($\bar{n} = 17$)	
	\bar{n}	Percent of total Ss	\bar{n}	Percent of total Ss	\bar{n}	Percent of total Ss
Between parents	7	15.9%	7	46.7%	4	23.5%
Between parent & child	8	18.2%	7	46.7%	1	5.9%
Involving subject as victim	9	20.5%	5	33.3%	1	5.9%
						14.8

Table 4.23

Occurrence of Financial Difficulties in Family of Origin

Family Member	Process Model (n = 44)		Structural Model (n = 16)		Systems Model (n = 17)	
	n	Percent of total Ss	n	Percent of total Ss	n	Percent of total Ss
Financial deprivation in family of origin	9	20.5%	4	26.7%	-	-
Parental employment difficulty	5	11.4%	21	13.3%	-	-
Parental employment necessitates time away from home	14	31.8%	1	6.7%	4	23.5%
Parent(s) whose employment necessitated period away from family						
mother	4	9.1%	-	-	-	-
father	10	22.7%	1	6.7%	3	17.7%
both parents	-	-	-	-	1	5.9%
<hr/>						
	n	X period Range	n	X period Range	n	X period Range
Period of time parent was away from home	9	2.9 yrs 1-9 yrs	1	.25 yr	4	1.4 yrs 2.4 yrs

Chapter 5: Summary, Conclusions, Limitations and Recommendations

This chapter provides an overall review of the process and results of the study. It is organized into four sections. First, the study's methodology is summarized. Second, conclusions based upon the data analyses are presented according the profiles of the Ss representing each model of family systems therapy. Third, limitations of the study are outlined, and fourth, recommendations for further research are set forth.

Summary

The purpose of the present study was to explore and describe certain psychosocial characteristics of therapists according to several theoretical orientations within the field of family systems therapy. These characteristics include psychological type, personality factors, and the occurrence of loss events in the family of origin. The theoretical orientations in the field of family systems therapy which were investigated are: Virginia Satir's Process model, Salvador Minuchin's Structural model, and Murray Bowen's Systems model.

While a number of studies have examined the psychological type preference (according to the Myers-Briggs Type Indicator) of therapists from various theoretical orientations (e.g., Levin, 1978; Perelman, 1977; Perry, 1975; Witzig, 1976), there is an absence of research on the type preferences of family therapists. Likewise, a substantial number of studies on the personality characteristics of therapists has been undertaken (e.g., Cottle, 1953; Kassera & Sease, 1970; Whitehorn & Betz, 1957, 1960; Walton, 1978), but the research concerning the personality characteristics of family therapists has been minimal. Kolevzon and Green's 1985 study provided the initial inquiry into the personality characteristics of family therapists; however, the emphasis of the study was more on how therapist practice converged or diverged from a chosen orientation, and less on what specific personality characteristics actually exist among family therapists. Research regarding the family of origin experiences of family therapists is lacking as well. Some studies of family of origin experiences of therapists have been undertaken (e.g., Burton, 1972; Henry, Spray, & Sims, 1971; Lackie, 1983; Racusin, Abramowitz, & Winter, 1981); however, the one therapist group which focuses specifically on family of origin experiences, family systems therapists, has been notably absent from the literature as a population for

study. Therefore, the present study attempted to fill this gap in the research regarding information about psychological type preferences, personality characteristics, and family of origin experiences of therapists from a family systems therapy theoretical orientation.

The population for this study consisted of 184 family therapists across the United States and Canada representing three different theoretical orientations within the family therapy field. Ss were chosen by major advocates of the particular models based on their training in and reflection of the principles of that model. Instrument packets were mailed to all 184 family therapists. These packets included a Client Information Form, a Consent Form, an Adjective Check List, and a Myers-Briggs Type Indicator. A return rate of 41.9% ($n=77$) was achieved. There was a substantial difference in the return rates from therapists in each model. Of the 64 therapists from the Process model who were sent instrument packets, 68.8% ($n=44$) returned the completed instruments. Of the 60 therapists from the Structural model who were sent packets, 26.7% ($n=16$) returned the completed instruments. Of the 60 therapists from the Systems model who were sent packets, 28.3% ($n=17$) returned the completed instruments. Therefore, the sample for this study was comprised of 77 family therapists representing three different theoretical orientations within the family therapy

field: 44 therapists from the Process model, 16 therapists from the Structural model, and 17 therapists from the Systems model.

Inquiry was made on variables of psychological type preference according to four scales of the Myers-Briggs Type Indicator, personality characteristics according to 10 scales of the Adjective Check List, and loss events in family of origin according to the Nodal Events Inventory (prepared by the researcher). Descriptive information on Ss was gathered from a Client Information Form. All instruments were coded by number so as to prevent recognition of names. Moreover, any information that would identify the particular site of a respondent's clinical practice was eliminated. An opportunity of Ss to request a copy of a summary of results was also provided.

Analysis of variance (ANOVA) was conducted on the results from the Myers-Briggs Type Indicator (MBTI) and the Adjective Check List to determine whether the three groups differed significantly among themselves. Statistical significance at the $p < .05$ level was reached on two scales from the MBTI: Thinking-Feeling ($p < .0001$) and Judging-Perceiving ($p < .001$). A post hoc analysis using Scheffe's t multiple range test was conducted in order to specify which of the three sample means differed significantly from one another on the two scales from the MBTI which showed

statistical significance. On the Thinking-Feeling scale, a significant difference at the $p < .05$ level was reached between the Systems model and the Process model, and between the Systems model and Structural model. On the Judging-Perceiving scale, a significant difference at the $p < .05$ level was reached between the Systems model and the Process model. No statistical significance was achieved on the 10 scales from the Adjective Check List. Descriptive statistics are provided for results from the Nodal Events Survey.

Conclusions

Demographic data gathered from the Client Information Form provide a basic profile of Ss from the three models of family systems therapy in the sample. Similarity was seen in the categories of race and marital status. Gender differences were noted but, because the Myers-Briggs Type Indicator and the Adjective Check List are adapted for gender, and gender is irrelevant for loss event information from the Nodal Events Survey, these differences are not considered important. Ss from the Process model were slightly older than those from other models and showed a wider range (35-81 years) of ages. This difference should be considered when examining data from the Nodal Events

Survey since older persons probably would experience more loss events in their lives than younger persons.

The results from the Client Information Form, beyond basic demographic information that describes the sample, reveal interesting differences and similarities in the clinical practice and family of origin backgrounds of family therapists from the Process, Structural, and Systems models. The primary setting for clinical experience prior to the current setting in which these therapists worked was a community mental health center, hospital/health center, or private practice. It would appear that other settings, such as corrections, social welfare, or even public family agencies, do not often serve as original employment settings for family therapists representing the three models investigated in the current study.

Differences in the client groupings commonly treated by family therapists reflect the practices of their particular models. Although Process model therapists reported treating individuals most frequently, these therapists saw their clients as couples, whole families, and in groups almost as frequently. It would appear that therapists using the Process model of family therapy find that model applicable with a variety of client groupings. On the other hand, it appears that treating whole families at one time is a standard practice for therapists who follow the Structural

model of family therapy. Treating couples only or individuals occurs much less frequently in Structural family therapy. Moreover, the use of Structural family therapy with groups appears to be rather infrequent. The clinical practice of the Systems model of family therapy appears to be primarily with individuals as well. Some treatment of couples occurred, but treating whole families occurred infrequently. Group treatment using the Systems model of family therapy appears also to be an infrequent practice.

Family therapists across all three models of family therapy come primarily from families of 3-5 siblings. However, different sibling positions are represented among the family therapists. Process model therapists are most frequently youngest siblings. On the other hand, Structural and Systems model therapists are most frequently oldest siblings in their families of origin.

Results from the MBTI indicated no statistical significance for the Introversion-Extroversion or for the Sensation-Intuition scales. Introverted types (59.2%) and Extraverted types (40.8%) were about equally found among Ss across the three models. However, it is noted that 89.9% of the total sample ($n=76$) were Intuitives. This is consistent with the findings of most other research on psychotherapists (Buchanan & Bandy, 1984; Galvin, 1975; Levin, 1978; Perry, 1975). Statistically significant differences among Ss from

the three models of therapy on the Thinking-Feeling and the Judging-Perceiving scales were found.

Results on the Thinking-Feeling scale of Myers-Briggs Type Indicator revealed that Systems model Ss in this sample were significantly different in their orientation toward Thinking from Ss in the Process and Structural models (whose orientation toward Thinking preference was not as frequent). Process and Structural model Ss were not statistically different in the orientations on the Thinking-Feeling scale.

Results on the Judging-Perceiving scale of the Myers-Briggs Type Indicator revealed that Systems model Ss in this sample were significantly different in their orientation toward Judging from Ss in the Process model (whose orientation toward Judging preference was not as frequent). Systems and Structural model Ss were not significantly different in their orientations on the Judging-Perceiving scale, nor were Structural and Process model Ss significantly different in their orientations on the Judging-Perceiving scale.

Systems model Ss were characterized overwhelmingly as Thinking types. According to the MBTI manual, Thinking types "develop characteristics associated with thinking: analytical ability, objectivity, concern with principles of justice and fairness, criticality, and an orientation toward time that is concerned with connections from the past

through the present and toward the future" (Myers & McCaulley, 1985, p.12). Thinking types can be described as "tough-minded." Thinking types are most often characteristic of theoretical orientations that value cognitive activity using quantitative data, and are frequently confrontive, such as behavioral and RET psychotherapies (Levin, 1978). Psychology students are characteristically Thinking types, compared to social work students, who tend to be Feeling types (Durfee, 1971). Thinking types are interested in the distinctive behavior patterns of their clients (Perelman, 1977).

Systems model Ss were also characterized as Judging types (87.50%). According to the MBTI manual, Judging types are persons "concerned with making decisions, seeking closure, planning operations, or organizing activities" (Myers & McCaulley, 1985, p.14). In combination with the Intuitive type, Judging types make plans and decisions based on logical analyses of the facts at hand. Judging types are most often characteristic of theoretical orientations that value logic and planning, such a RET, behavioral, and psychoanalytic therapies (Levin, 1978).

Thus, it appears that the particular preference characteristics of Intuitive, Thinking and Judging types are stereotypically found among therapists who practice the Systems model of family therapy. This is not surprising,

since the Systems model values logic, criticality, analytical thinking, organization, objectivity, and planning. This multigenerational model of family therapy is a highly theoretical model which relies heavily on client insight in order to achieve its goal of improved differentiation, a principle consistent with the Intuitive type. More oriented to the past than other models of family therapy, the Systems model reflects the Thinking type's preference for making connections between the past and the future through the present. Systems model therapists strive to maintain a neutral stance with clients that would more often appear "tough-minded" than "tender-minded," which also is a characteristic of Thinking types. The practice of Systems model family therapy, clearly based on an understanding of and adherence to the tenets of Bowen Theory, reflects an appreciation of logic and organization that is characteristic of Judging types.

Process model Ss, significantly different from Systems model Ss, were characterized by Feeling types. Feeling type persons are strongly considerate of personal and group values; therefore, they are inclined to be more subjective in their thinking than Thinking types. Feeling types "attend to what matters to others . . . have and understanding of people, a concern with the human as opposed to the technical aspects of problems . . . a desire for

harmony, and a time orientation that includes preservation of the values of the past" (Myers & McCaully, 1985, p.13). Feeling types can be described as "tender-minded." Feeling types are most often characteristic of theoretical orientations which value the examination of the inner self, such as experiential, Gestalt, or psychoanalytic therapies (Levin, 1978). Feeling types are more often found among social work students than psychology students (Durfee, 1971). Feeling types are especially attuned to the quality of the client-therapist relationship (Perelman, 1977), and are more accommodating than confrontive in conflict-handling practices (Kilmann & Thomas, 1975).

Intuitive, Feeling types are the most characteristic type preferences that occur among Process model therapists. This model of family therapy, with its emphasis on affect, communication, improved self-worth, and congruency, also strives for insight that will assist in the establishment of healthy connections and reconnections in the lives of clients. These characteristics are reflected in the tendency of Intuitive types to identify patterns by way of insight, and the orientation of Feeling types toward establishing harmony (congruency), and valuing the feelings (affect) of those around them. The Feeling type preference for the subjective and concern with human beings rather than

technical matters clearly finds a home in the Process model's more practical, less theoretical nature.

Judging and Perceiving types are equally likely to occur among family therapists from the Process model. Persons who valued logic and objectivity in planning and decision-making (Judging types) were as likely as those who valued spontaneity and adaptability (Perceiving types) to be Process model therapists. It appears that the practice of Process model family therapy can utilize persons with diverse orientations as therapists as long as the basic orientation toward Feeling preference is present.

Structural model Ss in this sample were almost equally divided between Thinking and Feeling types. Therefore, those "tough-minded" individuals with a bent toward analytical and objective thinking (Thinking types) were just as likely to be Structural model therapists as "tender-minded" Perceiving types who seek harmony and attend to the values of those with whom they are dealing. It appears that the qualities identified with Thinking and Feeling types are equally valuable in assisting Structural model therapists to recognize how the structure of a family creates and maintains dysfunctional behavior.

Structural model Ss were most frequently Judging types. Judging types are persons "concerned with making decisions, seeking closure, planning operations, or organizing

activities" (Myers & McCaully, 1985, p.14). In combination with the Intuitive type, Judging types make plans and decisions based on logical analyses of the facts at hand. Judging types are most often characteristic of theoretical orientations which value logic and planning, such as RET, behavioral, and psychoanalytic therapies (Levin, 1978). Therapeutic practice of the Structural model calls for deliberate planfulness based on an adequate analyses of the family's structure. Thus, the characteristics of Judging types are particularly useful in this model.

In summary, the present study found that the psychological preference for Intuition is strongly characteristic of all family systems therapists, as it is for psychotherapists in general. Thinking-Judging types are strongly characteristic of Ss representing the Systems model of family therapy. Process model Ss tended toward Feeling types. However, a stereotypical description of Process and Structural model Ss according to preferences for Extroversion-Introversion, Thinking-Feeling, or Judging-Perceiving is not revealed.

In general, there were few remarkable events in the family of origin experiences of therapists representing the three models of family therapy in this study. Early lives of disruption and upheaval were not established (unlike those in Burton's 1972 study of 12 successful male

psychotherapists). Most death events of family of origin members were experienced by these family therapists as adults. Most serious illnesses of family members were experienced as adults, with the exception of Systems model therapists, who more frequently experienced their mother's deaths in adolescence. Disability/handicapping occurrences and institutionalizations of family members were not distinctive.

Family separations were rarely experienced in the families of origin of Process, Structural, and Systems model therapists, although the therapists who had had this experience, did so as children. This finding is in contrast to that of Henry (1977), and Henry, Spray, and Sims (1971), who reported at least half of their sample had experienced some form of separation in childhood or adolescence.

One particular event in the family of origin experience of family therapists is noteworthy. There was a high incidence of physical/emotional abuse reported by Structural model therapists. While there were reports of such abuse by therapists from the Process and Systems models, they were not as high as those from the Structural model.

The occurrence of drug and alcohol abuse in the families of origin of therapists from the three models of family therapy, likewise, does not appear to be noteworthy. Only Structural model therapists reported drug abuse

(fathers and mothers), but the incidence was low. Systems model therapists reported the highest incidence of alcohol abuse in their families of origin, but this was confined largely to the category of Other Significant Relatives, not their closer relatives.

Process model therapists experienced more moving events before the age of 18 years than did those from the Structural and Systems models, but even those moves were mostly within the same general area. Thus, the impact of those moves as loss events is mediated somewhat.

Financial difficulties in the family of origin appears more commonly to have been experienced by Process and Structural model therapists. The absence of a parent from home due to employment is noted with some frequency in the Process and Systems models, but not among therapists from the Structural model.

Therefore, results from the Nodal Events Survey are largely consistent with the findings of Henry (1977) and Henry, Spray, and Sims (1971) in that the occurrence of traumatic events in the families of origin of therapists (in the present case, family therapists) appears to be normal. The notable exception is that of the Structural model therapists, who reported a high incidence of physical/emotional abuse occurring in their families of origin.

Limitations

Conclusions based on results from this study must be approached cautiously due to the small and unequal size of the three groups. Statistical analyses used on the Myers-Briggs Type Indicator and the Adjective Check List are especially effected by the small sample: the smaller the n , the less sensitive to difference is the statistical procedure. Descriptive statistics used to report results from the Nodal Events Survey, likewise, must be approached with caution. The use of percents, necessary due to the unequal group sizes, can be misleading. Ranges are given when appropriate in order to further clarify the results.

Self-report questionnaires are always problematical. Those subjects who completed the instruments may do so in a way that will, as they interpret it, make their group (family therapy model) look "good." Or, in concern about confidentiality issues, a respondent may not respond to all items completely and truthfully.

A limitation especially present in this study concerns the question of generalizability of results based on such a small sample. Results should reflect the characteristics of the sample; however, since a large number of persons chose not to participate, it may be that the sample does not adequately represent the group it intends to portray. It

may be, for instance, that all those persons who do not fit the common type preference of NTJ for Systems model therapists were exactly the ones who did not participate in the study. To generalize the findings that Systems model therapists are characteristically NTJs to portray all Systems model therapists may, then, be inappropriate.

Recommendations

Obviously, the foremost recommendation for further study would be to use a larger sample. This is especially important with the Systems and Structural models, where the response rate in the present study was so low.

Other theoretical orientations within the family systems therapy field exist and ought to be included in further studies of the characteristics of family therapists. An equivalent group of therapists well-trained in others models (e.g., strategic family therapy) could be compared to the groups used in this study. Since there are also family therapists who are more eclectic in their approaches, and less inclined to identify with a particular model of family therapy, the psychosocial characteristics of these therapists also ought to be investigated. It would be interesting to see how that group of family therapists compares to those family therapists who identify themselves

with a particular theoretical orientation within the family therapy field.

A small sample using personal interviews with family therapists regarding various family of origin events or issues would provide more depth in that area. Moreover, inquiry into how family of origin events may or may not have influenced the choice of a particular theoretical model of family systems therapy could be made.

Another way of examining information on psychological preference type is to establish the frequency at which certain preference types occur among therapists from various models of family therapy and across the family therapy field. Such examination would go beyond establishing the single element of bi-polar preferences, and instead explore the relationship among bi-polar type preferences.

Finally, the establishment of general profiles of therapists identified with specific models of family therapy would be useful in training student therapists. Once type preference, personality characteristics, and family of origin information is established for a student, these characteristics can be compared to those of certain models of family therapy, and the student advised that he/she may find this or that model of family therapy most comfortable for their own practice.

Appendix A: NODAL EVENTS SURVEY

Code # _____

NODAL EVENTS SURVEY

This survey is designed to elicit information on certain nodal events that commonly occur in a person's lifetime. Answer the questions from your own experience in your FAMILY OF ORIGIN. If you were adopted, complete the survey for your adoptive family experience. Many of these items ask for your age when the event occurred; please estimate your age as nearly as you can recall. Use "B" if the event occurred before your birth. It might be helpful to look over the entire survey before completing.

	Yes	No	Your Age
1. Were you adopted?	_____	_____	_____
2. <u>Deaths in Family</u>			
Father	_____	_____	_____
Mother	_____	_____	_____
Stepmother/female guardian	_____	_____	_____
Stepfather/male guardian	_____	_____	_____
Sister	_____	_____	_____
Brother	_____	_____	_____
Grandmother (maternal)	_____	_____	_____
Grandfather (maternal)	_____	_____	_____
Grandmother (paternal)	_____	_____	_____
Grandfather (paternal)	_____	_____	_____
Other significant relative relationship: _____	_____	_____	_____
Suicide relationship: _____	_____	_____	_____
Murder relationship: _____	_____	_____	_____

	Yes	No	Your Age
3. <u>Separations in Family</u>			
Whole family split up	_____	_____	_____
Parents separated	_____	_____	_____
One parent deserted family	_____	_____	_____
4. <u>Serious Illness in Family</u>			
Father	_____	_____	_____
Mother	_____	_____	_____
Stepmother/female guardian	_____	_____	_____
Stepfather/male guardian	_____	_____	_____
Sister	_____	_____	_____
Brother	_____	_____	_____
Grandmother (maternal)	_____	_____	_____
Grandfather (maternal)	_____	_____	_____
Grandmother (paternal)	_____	_____	_____
Grandfather (paternal)	_____	_____	_____
Other significant relative relationship: _____	_____	_____	_____
You	_____	_____	_____
5. <u>Family Member Disabled or Handicapped</u>			
Father	_____	_____	_____
Mother	_____	_____	_____
Stepmother/female guardian	_____	_____	_____
Stepfather/male guardian	_____	_____	_____
Sister	_____	_____	_____
Brother	_____	_____	_____
Grandmother (maternal)	_____	_____	_____
Grandfather (maternal)	_____	_____	_____
Grandmother (paternal)	_____	_____	_____
Grandfather (paternal)	_____	_____	_____

	Yes	No	Your Age
5. <u>Family Member Disabled or Handicapped. cont.</u>			
Other significant relative relationship: _____	_____	_____	_____
You	_____	_____	_____
6. <u>Family Member Placed in Institution</u> (mental hospital, jail, prison, etc.)			
Father	_____	_____	_____
Mother	_____	_____	_____
Stepmother/female guardian	_____	_____	_____
Stepfather/male guardian	_____	_____	_____
Sister	_____	_____	_____
Brother	_____	_____	_____
Grandmother (maternal)	_____	_____	_____
Grandfather (maternal)	_____	_____	_____
Grandmother (paternal)	_____	_____	_____
Grandfather (paternal)	_____	_____	_____
Other significant relative relationship: _____	_____	_____	_____
You	_____	_____	_____
7. Please note any <u>other events</u> which you consider significant.			
Event			Your Age

8. How many times did you move before age 18 years? _____			

9. How many of these moves were:
- within the same general area? _____
 - to another state? _____
 - to another geographic region? _____
 - to another country? _____

Below is a list of problems which often occur in families.
Please check only those problems that occurred in the family
you were raised in.

10. Alcohol Abuse

- Father _____
- Mother _____
- Brother or Sister _____
- You _____
- Other (please list relationship): _____
- _____
- _____

11. Drug Abuse

- Father _____
- Mother _____
- Brother or Sister _____
- You _____
- Other (please list relationship): _____
- _____
- _____

12. Physical/Emotional Abuse

- Between parents _____
- Between parent and child _____
- Abuse involved you as victim _____

13. Family struggling for enough money
for food, clothing, housing _____

14. Minimal work available for
parents to earn a living _____
15. Did the employment of any of the parenting adults
necessitate periods away from the family?
yes _____ no _____ length of time _____
which parenting adult(s): _____
16. Please note any other issues which you consider to be
significant in your family of origin as it might affect
your approach to psychotherapy:

Appendix B: THERAPIST INFORMATION FORM

Code # _____

THERAPIST INFORMATION FORM

1. Age: _____
2. Sex: _____ male _____ female
3. Race: _____
4. Marital Status: _____ single _____ married
_____ widowed _____ separated/divorced

5. Formal Education:

Degree	Year	Major or Discipline
Bachelors	_____	_____
Masters	_____	_____
Doctorate	_____	_____
other	_____	_____

6. Professional Experience:

Setting	Current	Previous
Community Mental Health Center	_____ years	_____ years
Corrections	_____ years	_____ years
Counselor Education	_____ years	_____ years
Hospital/Health Center	_____ years	_____ years
Family Agency (public)	_____ years	_____ years
Pastoral Counseling	_____ years	_____ years
Private Practice	_____ years	_____ years
Psychiatric Nursing	_____ years	_____ years
School/Guidance Counseling	_____ years	_____ years
Social Service/Welfare Agency	_____ years	_____ years
Other _____	_____ years	_____ years
_____	_____ years	_____ years

7. Current Client Caseload:

Please indicate what percent (approximate) of your current Identified Client caseload is with (family systems therapy with one client is considered here to be "individual");

Individuals	_____	%
Couples	_____	%
Families	_____	%
Groups	_____	%
	<u>100%</u>	

Do you wish a summary of the research results sent to you?_____

8. Which adults were most responsible for parenting duties for you as you were growing up?

mother	_____
father	_____
grandmother	_____
grandfather	_____
aunt	_____
uncle	_____
nonrelated guardian	_____

9. How many brothers and sisters did you have while growing up?

brothers _____ sisters _____ (not including you)

10. What is your sibling position?

oldest brother of brother(s) _____

youngest brother of brother(s) _____

oldest brother of sister(s) _____

youngest brother of sister(s) _____

male only child _____

oldest sister of sister(s) _____

youngest sister of sister(s) _____

oldest sister of brother(s) _____

youngest sister of brother(s) _____

female only child _____

oldest brother of brother(s) & sister(s) _____

youngest brother of brother(s) & sister(s) _____

oldest sister of brother(s) & sister(s) _____

youngest sister of brother(s) & sister(s) _____

other? (describe) _____

11. Which generation (approximately) do you represent since your family of origin immigrated to the United States or Canada?

don't know _____

first _____

second _____

third _____

fourth or more _____

12. What do you consider the primary ethnic/regional influences within your family of origin (i.e., Southern/Hispanic/German)? _____

Appendix C: CONSENT FORM

CONSENT FORM

The purpose of this study, Characteristics of Family Therapists, is to investigate certain psychosocial characteristics of family therapists according to various theoretical orientations within the family therapy field. Information gained from this study will assist in designing training programs for therapists which will make the best use of individual preferences, traits, and experiences in selecting a theoretical orientation. The results of this study will also provide further information on the person of the therapist, and how that personhood affects and is affected by a peculiar theoretical orientation in the psychotherapeutic field.

Some of the questions in this study are potentially sensitive and personal. Therefore, all precautions to insure complete confidentiality will be taken. Instruments are coded by number, not by name. The list matching names and numbers will be viewed only by the researcher and her faculty advisor, and will be destroyed as soon as all data is encoded for analysis. Results will be reported according to theoretical orientation; individual results will not be available.

Your participation in this study is voluntary and will be reported anonymously. Please sign below to indicate your consent to participation in this study and return this form together with all other instruments in the envelope provided. If you choose not to participate, simply return the instruments in the envelope provided. If you have any questions, please contact the researcher (collect):

Keren M. Humphrey, 1305 London Co. Way, Williamsburg, Virginia 23185; (804) 229-8952.

I am willing to participate in the study,
Characteristics of Family Therapists. I understand that my participation is voluntary and that precautions to protect confidentiality are being taken.

Signature: _____

Date: _____

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Abstract

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The purpose of this study was to explore and describe certain psychosocial characteristics of family therapists according to three different theoretical orientations within the family systems field. The characteristics examined were psychological type preference, personality factors, and the occurrence of loss/transition events in the family of origin.

A review of the literature revealed that, while some research on psychological type preferences and personality characteristics of therapists from various theoretical orientations has been undertaken, there is a serious lack of research on therapists representing the various models of family therapy. Additionally, there has been very little research done on family of origin experiences of therapists in general, and of family therapists specifically.

The sample for this study consisted of 77 family therapists across the United States and Canada representing three different theoretical orientations within the family therapy field: Satir's Process model, Minuchin's Structural

model, and Bowen's Systems model. Ss were chosen by major advocates of the particular models based on their training in and reflection of the principles of that model. All Ss completed an instrument packet containing a Myers-Briggs Type Indicator, an Adjective Check List, and two instruments prepared by the researcher; a Nodal Events Survey, and a Client Information Form. Analysis of variance (ANOVA) was conducted on the results for four scales of the Myers-Briggs Type Indicator (using continuous scores) and ten scales of the Adjective Check List. Data gathered from the Client Information Form and the Nodal Events Survey were reported according to descriptive statistics.

Data from the Myers-Briggs Type Indicator indicated that 59.2% of the total Ss were Introverted types and 89.9% were Intuitive types. Results from the Myers-Briggs Type Indicator revealed that Systems model Ss were significantly different ($p < .05$) from Ss from the Process and Structural models in their strong orientation toward Thinking on the Thinking-Feeling scale. Process and Structural model Ss were not significantly different in their orientations on the Thinking-Feeling scale. Additionally, Systems model Ss were significantly different ($p < .05$) from the Ss from the Process model in their orientation toward Judging on the Judging-Perceiving scale. Systems and Structural models Ss were not significantly different in their orientations on

the Judging-Perceiving scale, nor were Structural and Process model Ss significantly different in their orientations on the Judging-Perceiving scale. Statistical significance was not reached on ten scales from the Adjective Check List.

There were few remarkable events or differences in the loss/transition events in family of origin experiences of Ss. Most serious illnesses of family members were experienced by Ss as adults, with the exception of Systems model Ss, who more frequently experienced their mother's deaths during their adolescence. There was a high incidence (46.7%) of family of origin physical/emotional abuse reported by Ss from the Structural model.

Demographic data indicated that most Ss had worked at a community mental health center, hospital/health center, or private practice prior to their current employment setting, which was most frequently private practice. Investigation of client caseload revealed that Systems model Ss most frequently treated clients as individuals; Structural model Ss most frequently treated clients as whole families; and Process model Ss, while most frequently treating clients as individuals, also frequently treated couples, whole families, and groups. Ss across the three models were primarily from families of 3-5 siblings. Process model Ss were most frequently youngest siblings, while Structural

model and Systems mode Ss were most frequently oldest siblings.

Results from this study indicate some differences of psychological type preference among therapists from three theoretical orientations within the family therapy field. No statistically significant differences were reported on personality characteristics.